STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433442	A. BUILDING _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY RURAL HEALTH CLINIC	102 MAJOR ALLEN MARTIN, SD 57551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
J 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 491, Subpart A, requirements for rural health clinics, was conducted on 11/20/24. Bennett County Rural Health Clinic was found not in compliance with the following requirements: J0041, J0043, J0135, J160, J161, and J162.	J 000		
J 041	PHYSICAL PLANT AND ENVIRONMENT CFR(s): 491.6(a) 491.6(a) Construction: The clinic and the center is constructed, arranged, and maintained to insure access to and safety of patients, and provides adequate space for the provision of direct services. This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to ensure two of three oxygen tanks, stored in the procedure room, had been secured. Findings include: 1. Observation on the morning of 11/20/24 revealed three oxygen tanks in the procedure room. One oxygen tank was loaded on a wheeled cart for transporting. Two additional oxygen tanks were sitting on the floor, against the wall, unsecured. Interview on 11/20/24 at 11:55 with chief executive officer A revealed she had not been aware the oxygen tanks had not been secured in the procedure room.	J 041	On November 20, 2024, the clinic was cited under Tag J041 for failing to ensure proper storage of oxygen tanks in the procedure room, where two out of three tanks were found unsecured on the floor against the wall. Immediate corrective action was taken on 11/20/24 to secure the tanks in compliance with safety standards by the Maintenance Manager. The oxygen storage policy will be reviewed and updated to include detailed storage guidelines, with the CEO or designee responsible for all policy updates and staff education. All staff will be trained on proper handling and storage procedures. Weekly inspections, overseen by the Maintenance Supervisor, will be implemented by to ensure continued compliance, with results reviewed monthly by Quality Assurance Performance Improvement (QAPI) committee which includes representatives from each service area as well as the facility Medical Director monthly for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024
J 043	PHYSICAL PLANT AND ENVIRONMENT CFR(s): 491.6(b)(2) The clinic . . . has a preventive maintenance	J 043		

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

CEO 12/11/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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J 043	Continued From page 1 program to ensure that: 491.6(b)(2) Drugs and biologicals are appropriately stored; and This STANDARD is not met as evidenced by: Based on observation, policy review, and interview, the provider failed to monitor expiration dates of biologicals and supplies to ensure patient safety throughout the building. Findings include: 1. Observations made during the morning of 11/20/24 of biologicals and supplies in examination (exam) rooms one, two, three, four, five, and six; the procedure room; the hallway supply closet; and the laboratory revealed the following were available for patient or staff use: a. Exam room one: *One four-ounce bottle of Hibiclens (chlorhexidine gluconate solution four % w/v [weight/volume]) (antiseptic/antimicrobial skin cleanser) expired 4/22. b. Exam room two: *One eight-ounce bottle of Hibiclens expired 9/20. *Eleven single use packages of lubricating jelly expired 11/1/21. *One four-ounce bottle of Aplicare povidone-iodine solution (antiseptic) expired 1/19. c. Exam room three: *Three four-ounce bottles of Hibiclens expired 6/24. *Two ten-milliliter syringes of 0.85% Sodium Chloride Inj (injectable) USP intravenous flush solution expired 5/31/24. d. Exam room four: *Three four-ounce bottles of Hibiclens expired 6/24. *Twelve single use packages of lubricating jelly expired 11/1/21.	J 043	On November 20, 2024, the clinic was cited under Tag 491.6(b)(2) for failing to monitor expiration dates of biologicals and supplies throughout the building, compromising patient safety. Immediate corrective actions included removing and properly discarding all expired biologicals and supplies from exam rooms, the procedure room, the laboratory, and the hallway supply closet as of 11/21/24. Development and approval of a new policy for monitoring biologicals and supplies will be finalized, with the CEO or designee responsible for all policy updates and staff education. All staff will receive training on the updated policy and procedures for inventory management and monitoring. Monthly inspection checklists of all storage and supply areas will be implemented, conducted by clinic staff and overseen by the Clinic Manager. Results of these inspections will be reviewed monthly by QAPI Committee for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024

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J 043	Continued From page 2 *Five single use packages of lubricating jelly expired 7/18. e. Exam room five: *One four-ounce bottle of Hibiclens expired 6/24. *Three Hemocult (fecal occult blood) stool testing cards expired 1/21. f. Exam room six: *One eight-ounce bottle of Hibiclens expired 4/22. *Two four-ounce bottles of Hibiclens expired 6/24. *One eight-ounce bottle of Skin Tegrity Wound Cleanser expired 11/15/24. g. Procedure room: *Sixteen four-ounce bottles of Hibiclens expired 6/24. *One package of Skin Prep Protective wipes expired 7/22. *Four single use packages of lubricating jelly expired 7/18. *One package Vyaire Connector Clip DLAR Surelock clips (used for performing electrocardiograms [EKG]) expired 6/5/20. *One package Kendall 5400 Diagnostic Tab Electrodes (used for performing EKGs) expired 9/20/21. *One package Kendall 5400 Diagnostic Tab Electrodes (used for performing EKGs) expired 6/9/24. *Eleven packages of Philips Solid Gel disposable diagnostic electrodes (used for performing EKGs) expired 6/19/22. *One four-ounce bottle of Aplicare povidone-iodine solution expired 1/19. *One bottle of Sodium Chloride Irrigation USP 100 ml solution expired 9/3/23. *One bottle of Curity Plain Packing Strip 1/4 X 15 inch bandage material expired 12/20. *Two 500 milliliter bottles of sterile water expired 6/28/23. h. Hallway supply closet:	J 043		

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J 043	Continued From page 3 *One box containing Opb ER-Spec, size medium, speculums expired 9/14/23. *One box containing Opb ER-Spec, size medium, speculums expired 11/11/23. *One box containing Opb ER-Spec, size large, speculums expired 11/4/24. *One box containing single use packages of lubricating jelly expired 11/1/22. i. Laboratory: *One container of Siemens Multistix 10G dipsticks (used for the chemical examination of patient urine specimens) expired 9/30/24. *One container of Hemo Point H2 testing strips (used for the determination of hemoglobin in patient blood specimens) expired 9/30/24. *Ten Thin Prep Pap Test collection containers expired 3/9/24. *One package of povidone-iodine swabs expired 9/26/23. Review of policies and procedures revealed the provider had not developed or implemented a policy that addressed the monitoring of expiration dates of biologicals and/or supplies. Interview on 11/20/24 at 11:55 AM with chief executive officer A revealed: *She was unaware of the expired supplies in the clinic. *She confirmed the clinic had not developed a policy for monitoring expiration dates of biologicals and supplies.	J 043		
J 135	PROVISION OF SERVICES CFR(s): 491.9(a)(3) and 491.9(c)(2) 491.9(a) Basic requirements: (3) The laboratory requirements in paragraph (c)	J 135		

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J 135	Continued From page 4 (2) of this section apply to RHCs, . . . 491.9(c) Direct services (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) Hemoglobin or hematocrit; (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 (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 patient testing. Interview on 11/20/24 during the survey with physician assistant B revealed the hospital laboratory staff processed most laboratory requests. He did not think the clinic had any urine pregnancy tests available within the clinic.	J 135	On November 20, 2024, the clinic was cited under CFR 491.9(a)(3) and 491.9(c)(2) for failing to ensure the availability of urine pregnancy tests, a required laboratory service essential for immediate diagnosis and treatment. Immediate corrective action was taken on 11/21/24 by obtaining and stocking urine pregnancy test kits in the clinic. A new policy will be implemented to ensure the consistent availability of all required laboratory supplies in the clinic, including urine pregnancy tests. The CEO or designee will be responsible for all policy updates and staff education. Staff will be trained on the updated policy and the importance of maintaining compliance with laboratory service requirements. Routine monthly inventory checks of urine tests in the clinic, overseen by the Clinic Manager, will be conducted and reported to QAPI Committee monthly for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024

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J 135	Continued From page 5 Interview on 11/20/24 at 11:55 AM with the chief executive officer A revealed: *She confirmed the hospital laboratory collected and processed the patient specimens for laboratory testing required by the clinic. *She had not been aware the clinic did not have urine pregnancy tests in the clinic.	J 135		
J 160	PROGRAM EVALUATION CFR(s): 491.11 §491.11 Program evaluation. This CONDITION is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure policies and procedures had been established and implemented to perform biennial (every two years) program evaluations. 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 any other evaluations that had been performed in previous years. There were no records or policies that indicated the provider: *Had identified who was to perform the program evaluations nor how or when the evaluation would be done. *Had evaluated the typr of services provided. *Had assessed the implementation of policies	J 160	On November 20, 2024, the clinic was cited under §491.11 for failing to establish and implement policies and procedures to perform biennial program evaluations as required. Corrective action will be initiated to draft and adopt a comprehensive policy detailing the process, timeline, and responsibilities for conducting biennial program evaluations, including assessments of services, implementation of policies and procedures, patient record reviews, and summary reports with recommendations. The CEO or designee will be responsible for all policy updates and staff education. Leadership will conduct an initial program evaluation to address the gap, identify improvements, and align with compliance requirements. Staff will receive training on the new policy and evaluation procedures. A schedule for regular evaluations will be implemented to ensure ongoing compliance, with results reviewed by QAPI Committee monthly for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024

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J 160	Continued From page 6 and procedures. *Had reviewed open and closed patient medical records. *Had reviewed a summary report with recommendations for improvement, if necessary. Refer to J161. *Had determined if changes in patient care related policies were needed or if supervision or clinical privileges needed to be made, or if recommendations had been made and addressed by leadership. Refer to J162.	J 160		
J 161	PROGRAM EVALUATION CFR(s): 491.11(a)-(c) § 491.11 Program evaluation. (a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program. (b) The evaluation includes review of: (1) The utilization of clinic or center services, including at least the number of patients served and the volume of services; (2) A representative sample of both active and closed clinical records; and (3) The clinic's or center's health care policies. (c) The purpose of the evaluation is to determine whether: (1) The utilization of services was appropriate; (2) The established policies were followed; and	J 161	On November 20, 2024, the clinic was cited under §491.11 for failing to conduct biennial evaluations of its total program as required. To address this deficiency, the clinic will implement the following corrective actions. A policy and procedure for conducting biennial program evaluations will be developed, specifying who will perform the evaluation, the timeline, and the methodology. The evaluation will include a review of clinic service utilization (including patient volume and types of services provided), a representative sample of both active and closed patient records, and the clinic's healthcare policies. The CEO or designee will be responsible for all policy updates and staff education. Leadership will complete an initial evaluation to establish a baseline and determine whether service utilization is appropriate, policies are being followed, and any changes are needed. Staff will be trained on the new policy and evaluation process to ensure ongoing compliance. A schedule for regular evaluations will be implemented to ensure ongoing compliance, with results reviewed by QAPI Committee monthly for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024

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J 161	Continued From page 7 (3) Any changes are needed. This STANDARD is not met as evidenced by: Based on interview and lack of records, the provider failed to: *Identify who was to perform the program evaluations nor how or when the evaluation would be done. *Evaluate the types and services provided. *Assess the implementation of policies and procedures. *Review open and closed patient medical records. *Take any needed corrective actions, or to make any changes to policies and procedures or 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 had been required. *She was unaware 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.	J 161		
J 162	PROGRAM EVALUATION CFR(s): 491.11(d) 491.11(d) The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.	J 162		

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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 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 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 recommended as a result of the evaluation or if different actions were taken than those recommended.	J 162	On November 20, 2024, the clinic was cited under §491.11(d) for failing to assess the findings of biennial program evaluations and take corrective actions as necessary. To address this, the clinic will implement the following corrective actions. A formal policy and procedure for reviewing evaluation findings and determining necessary corrective actions will be established. This policy will outline responsibilities, including who will review findings, how decisions will be documented, and timelines for implementation of corrective actions. The CEO or designee will be responsible for all policy updates and staff education. Leadership will conduct an initial review of clinic operations, identify areas for improvement, and implement necessary changes to patient care services, supervision, clinical privileges, and staff training. A structured process for documenting evaluation findings, recommendations, leadership decisions, and actions taken 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 ongoing compliance, with results reviewed by QAPI Committee monthly for 3 months, and then proceed per findings and Committee recommendations.	12/30/2024

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 491.12, Subpart A, Emergency Preparedness requirements for rural health clinics, was conducted on 11/20/24. Bennett County Rural Health Clinic was found not in compliance with the following requirement: E0042.	E 000		
E 042	Integrated EP Program CFR(s): 491.12(e) §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.102(e), §485.68(e), §485.542(f), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.	E 042	Facility will review and modify the Emergency Preparedness Program (EP Program) to integrate the Rural Health Clinic (RHC) and achieve a unified program representative of all healthcare systems offered. This will be the responsibility of the CEO, or designee, in conjunction with facility EP Program Officer and will be achieved by the following plan: 1. Clinic Manager or designee will participate in the development of the unified emergency preparedness program facilitated through involvement at emergency preparedness meetings and education, and participation in facility monthly Quality Assurance Performance Improvement (QAPI) meetings. 2.CEO and Emergency Preparedness Officer will insure that circumstances unique to the Rural Health Clinic, its patient population, and services are included in facility's unified EP Program. 3.CEO and Emergency Preparedness Officer will ensure that RHC staff are capable of actively using the integrated and unified EP Program in compliance through RHC staff inclusion in EP Program education events, table top exercises, and "hands on" simulated EP Program exercises. 4.CEO, or designee, in conjunction with EP Officer will perform an internal risk assessment unique to the RHC, as well as a community based risk assessment utilizing an all-hazards approach to both. These assessments will further guide development of the unified and integrated EP Program plan, policies and procedures. These assessments will also identify what resources the RHC could offer to the facility's Critical Access Hospital and/or the community in the event of an emergency.	12/30/2024

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

[signature] CEO 12/11/24

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BENNETT COUNTY RURAL HEALTH CLINIC	102 MAJOR ALLEN MARTIN, SD 57551

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E 042	Continued From page 1 (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This STANDARD is not met as evidenced by: Based on interview and record review, the provider failed to address its patient population, services offered, continuity of operations, resources, facility-based and community-based risk assessments in the health systems' emergency preparedness program which it was a part of. Findings include: 1. Interview on 11/20/24 at 11:55 AM with chief executive officer A revealed the provider was a part of a larger health system. The health system's emergency preparedness program had been developed to address the hospital. The clinic had not been involved in the development of	E 042	Continued from page 1: 5.Integrated policies and procedures will be developed by the CEO, or designee, in conjunction with EP Officer that will include the RHC in a coordinated communication plan and training and testing programs. These policies and procedures will specifically address actions the clinic would take in the event of an emergency. 6.Facility EP Program will be reviewed/updated biannually, or whenever there is a change in services or new internal or external hazards identified. This will be the responsibility of the CEO or designee and the EP Officer. CEO or designee will present policies and procedures for review as developed/modified and will report compliance of the above described unified and integrated EP Program monthly to facility QAPI committee, which includes representatives from each service area as well as the facility Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433442	A. BUILDING _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 042	Continued From page 2 the emergency preparedness plan. The plan had not included any specific information for the Bennett County Rural Health Clinic. Review of the health system's emergency preparedness program revealed: a. The above topics had not been identified or addressed for the rural health clinic, including specific actions the clinic would take in the event of an emergency. b. There was no documentation identifying what resources the clinic could offer to the attached hospital or the community in the event of an emergency.	E 042		