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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430077	A. BUILDING ______ B. WING ______	C 12/08/2023

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

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A 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals was conducted from 11/28/23 through 11/30/23 and from 12/4/23 through 12/8/23. Areas surveyed included patient rights, safety, abuse/neglect, restraints, privacy, dignity, and nursing services involving patient pressure ulcers. Monument Health Rapid City Hospital was found not in compliance with the following requirements: A115, A143, A154, and A385. On 11/30/23 at 8:25 a.m. immediate jeopardy (IJ) was identified related to patient rights at A115, finding 1. On 11/30/23 at 9:50 a.m. chief executive officer U, vice president (VP) of quality and risk A, director of quality, safety, and risk B, performance engineer C, and VP of nursing Y were given verbal notice of the IJ and were provided with the IJ template. On 11/30/23 at 5:11 p.m. the provider's IJ removal plan was accepted. On 12/4/23 at 2:45 p.m. while onsite, the removal plan was verified and the IJ was removed after the completion of document review, observation, interview, education review, and policy review.	A 000		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on a review of the South Dakota Department of Health (SD DOH) complaint intake information, observation, interview, job	A 115	VP Quality, VP Nursing, Nursing Practice Consultant, and Mobility Safety team leads reviewed Restraint and Seclusion Use Policy, Fall prevention program policy, Federal and State regulations related to restraint use. Revisions to the Restraint and Seclusion policy include: added possible risks of using restraints, the use of 4 side rails is considered a restraint and can only be used when	02/08/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Pierce   TITLE: President   (X6) DATE: 1/18/24

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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description review, and policy review, the provider failed to ensure:
*One of one sampled patient (15) who was mentally and physically dependent upon the staff that he was safe from acts of inappropriate touching by a family member that occurred while receiving acute care in the hospital.
*The privacy and dignity for two of two sampled patients (14 and 19) who were at high risk for falls, self-harm, or elopement had been maintained through the use of a telesitter (two-way video camera).
*The use of restraints included the following:
-Physician's orders when initiating four side rails to prevent seven of seven sampled patients (2, 8, 14, 15, 27, 18, and 19) from voluntarily getting out of their hospital bed.
-A written informed consent from every patient or designated guardian prior to the use and implementation of restraints.
-Policies and procedures to support the use of multiple restraints simultaneously that would include side rails, bed alarms, wrist and/or ankle restraints, and chemical restraints for one of one sampled patient (17).
Findings include:

These failures have the potential to cause both physical and mental harm to all patients who are dependent upon the provider to ensure their safety and dignity were maintained while under their care.

NOTICE:
On 11/30/23 at 9:50 a.m. facility's chief executive officer U, vice president (VP) of quality and risk, performance engineer C, and VP of nursing Y was informed of an IJ situation related to patient rights at A115. The provider failed to ensure a

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ordered by a provider unless a stated exception exists and restraint documentation must be completed to include patient/surrogate education. Clarified in policy that patient/family/ surrogate request for the use of 4 side rails is also considered a restraint, clarified handcuffs are not a restraint but are a forensic or correction restriction, added the use of multiple restraints simultaneously must include orders for each restraint type, and added Telesitter Monitoring as an alternative to restraint/ seclusion. Removed from policy Fall Prevention Program is the exception of using 4 side rails to protect the patient from falling out of bed in the adult care areas.

Restraint and Seclusion policy was updated to include exceptions for the use of 4 side rails as a restraint as outlined by CMS A-0154 interpretive guidelines and State regulation 44:75:04:12 including: recovery from anesthesia, seizure precautions, side rails on a stretcher, during transport, patients receiving continuous IV sedation, certain types of therapeutic beds, and side rails used for age or developmentally appropriate pediatric patients.

VP Quality, VP Nursing, Nursing Practice Consultant, ICU Medical Director, and Medical Director Hospital Medicine and IT Application Analyst reviewed provider restraint order, and provider documentation regarding **risks**

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patient who was both mentally and physically vulnerable and dependent upon the staff to ensure his safety from inappropriate touching by a family member that had been observed while under the continuous observation from a telesitter on 9/8/23.

PLAN:
The facility provided the following acceptable removal plan on 11/30/23 at 5:11 p.m. for patient rights:

1. "Immediate interventions related to this individual patient:
*Notice to law enforcement.
*Notice to Adult Protective Services.
*Notice to internal leadership and physician.
*Notice to Black Hills Advocates who obtained emergency guardianship.
*Moved patient to different location.
*Restricted visitor access per Black Hills Advocates.
*Notified Department of Health.
*Began investigation to include chart review and interview of caregivers involved in caring for the patient.
*Completion date 11/29/23."

2. "Leadership support:
*Vice Presidents, Market President, and Human Resources were notified of departments impacted by mandatory education and developed a plan to distribute and complete immediate education.
*Completion date 11/30/23."

3. "Failed escalation and reporting to ensure patient safety-immediate education:
*Department leader or designee will provide immediate education to all staff that have contact

A 115 **and benefits for multiple use of restraints and documentation of least restrictive measures prior to restraint use.** Order updated to allow for the documentation of benefits outweigh the risks when using 4 side rails and multiple restraints simultaneously.

Legal Counsel, VP Quality, VP Nursing, Nursing Practice Consultant, and Performance Engineer reviewed and revised Consent to Treatment and Conditions of Admission to include consent for the use of restraints per Restraint and Seclusion Use Policy.

VP Quality, VP Nursing, Nursing Practice Consultant, and Mobility Safety team leads developed education to include **documentation of less restrictive alternatives prior to restraint use, benefits outweighing the risks documented by the provider when ordering single or multiple types of restraints simultaneously,** restraint consent as part of Consent to Treatment and Conditions of Admission, Restraint and Seclusion and Fall Prevention policy revisions. Education will be completed by medical staff, nursing, nursing assistants, paramedics, ED techs, PT, OT, ST, PT/OT/ST techs, imaging, patient transport, phlebotomists, respiratory therapy, transport, food and nutrition and medical staff by February 8, 2024. Caregivers and providers on leave will be required to complete education prior to the first worked shift. Department

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or potential contact with patients, including telesitters, students, and physicians.
*Education will include:
-Witnessed, Reported, or Suspicion of Abuse, Neglect, Sexual Assault/Misconduct is a mandatory report to the State's Attorney, Department of Social Services, or local law enforcement, and Department of Health.
-Refer to Suspected Abuse or Neglect of Elderly or Disabled Adults policy and Reportable Cases policy for reporting process.
-Reporting needs to occur immediately along with chain of command escalation and Risk Management notification.
-Education will be provided via email with read receipt confirmation.
*Completion date 12/4/23."

4. "Monitoring:
*Department director or designee will track education completion and report compliance to respective VP and Risk Management by 12/4 [12/4/23] and as needed thereafter until all caregivers, students, and physicians have completed the education in their respective department(s).
*Caregivers and physicians not able to complete education by 12/4 [12/4/23] will have access suspended by human resources until education has been completed.
*Caregivers and physicians on an approved leave will complete the education prior to the next worked shift which will be tracked by the department leader.
*Completion date 12/4/23."

The removal plan for the IJ was received and accepted on 11/30/23 at 5:11 p.m. On 12/4/23 at 2:45 p.m. the implementation of their plan was

A 115 director or designee will monitor education completion weekly and report to VP Quality and VP of Operations monthly.

Legal Counsel, VP Quality, VP Nursing, Nursing Practice Consultant, Performance Engineer discussed options for obtaining documented consent for the use of telesitter monitoring. Consent to Treatment and Conditions of Admission document was reviewed and revised to include the addition of continuous audio/ video monitoring, calling out specifically telesitter monitoring.

Policy Remote Sitter/Tele sitter was reviewed and revised by VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing. Revisions include the addition of process when privacy mode is needed or requested and when patient view can be re-instated.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing reviewed and revised electronic telesitter documentation to include the option to document action taken related to observations. Nursing Professional Development created a tip sheet for telesitters related to nurse aides charting objective documentation.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of

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verified and the IJ status was removed while the surveyors were onsite.

1. Review of the provider's 11/29/23 initial incident report investigation submitted to the SD DOH on suspicion/allegation of abuse/neglect of patient 15 by a family member on 9/8/23 revealed:
*The allegation type had been the use of profanity, gestures, or acts.
*The patient was not capable of providing an explanation of the event and not capable of participating in the investigation.
*The report was submitted to the SD DOH eighty-two days after the suspicion of abuse by the family member occurred and was observed by telesitter observer V (staff using the two-way video camera).
-An initial report should have been submitted to the SD DOH within 24 hours of the identification of physical abuse for inappropriate touching.
*The patient:
-Was not cognitively oriented and was nonverbal.
-Was developmentally disabled due to fetal alcohol syndrome.
-Had been admitted on 10/11/23 for constipation but had a recent admission on 8/31/23 through 9/12/23 after falling from a cliff while hiking.
-Was medically stable, but placement/discharge planning had been difficult.
*The brother currently had guardianship but the sister was attempting to obtain guardianship over the brother.
*The brother had been taking care of the patient at home before the 10/11/23 admission and he had not wanted to be his guardian any longer.
-The patient had become more difficult to care for and another placement for him was needed.
*On 11/29/23, nursing had made a comment about the sister being inappropriate, but when

A 115 Clinical Coordination and Staffing developed education to include privacy mode process, documentation of observations and escalation process, and telesitter monitoring consent. Education will be completed by all nurse aides who function as a telesitter by February 8, 2024. Caregivers on leave must complete education before the first worked shift. Nursing Director of Clinical Coordination and Staffing or designee will monitor education completion weekly and report to the Vice President of Quality and the Vice President of Operations monthly.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing developed education to include privacy mode process, and telesitter monitoring consent. Education will be completed by all patient facing providers and caregivers by February 8, 2024. Caregivers and providers on leave must complete education before the first worked shift. Department Director or designee will monitor education completion weekly and report to the Vice President of Quality and the Vice President of Operations monthly.

Human Resources, Nurse Practice Consultant, VP of Quality, and Nursing Director of Clinical Coordination and Staffing reviewed and revised the nurse aide job description. Changes to the description included the addition of the essential functions of telesitter while

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case management looked for documentation for the observed behaviors they could not find any.
*It had become known that some kind of inappropriate behavior was observed by a telesitter observer.
*Case management looked through the telesitter observer documentation in the electronic medical record (EMR) and found a comment from a telesitter observer on 9/8/23 at 6:29 p.m.
-The documentation stated that a family member had been touching the patient inappropriately in the private area.
-The documentation was not found until 11/29/23 that was eighty-two days after the incident.
*The telesitter observer had notified the primary nurse and the nurse managers.
*"According to the [nurse] leader on call who was called, she was told that the telesitter [observer] told the nurse something weird is going on with the sister under the blankets. According to the telesitter observer it was approximately 2 minutes between the sister beginning the behavior and the nurse entering the room (with the telesitter [observer] calling the nurse in between that time)."
*"Rapid City police department dispatch was contacted at about 11:00 a.m. on 11/29/23 and a report filed by myself [performance engineer C]."
*"When I [performance engineer C] and the Rapid City Police department officers interviewed the telesitter [observer], she said she saw the sister being touchy with the patient, that the sister reached under the blankets touching him almost like she was giving him a hand job. The telesitter [observer] said the sister's hands were down by the patient's private area under the blanket and moving up and down."
*"The officer asked if she visualized her hand on his penis and she said no, it was under the

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maintaining privacy and dignity when utilizing electronic monitoring. Nursing Director of Clinical Coordination and Staffing updated telesitter competency to include essential job functions and orientation checklist. Staff performing telesitter monitoring duties will complete this competency before anyone is deemed independent in the telesitter position. Telesitter competency was completed by all nursing aide staff who perform telesitter monitoring by February 8, 2024.

Human Resources, Nurse Practice Consultant, VP of Quality, and Nursing Director of Clinical Coordination and Staffing developed education to reflect the changes to the essential functions in the nurse aide job description. Education will be completed by all nurse aides who provide the telesitter function by February 8, 2024. Caregivers on leave must complete education before the first worked shift. Department Director or designee will monitor education completion weekly and report to the Vice President of Quality and the Vice President of Operations monthly.

VP Quality, VP Nursing, Market President reviewed and revised Tiered Safety and Quality Huddle process and documents to include the capture of potential abuse or neglect concerns during hospitalization to ensure escalation occurred and facilitate appropriate follow up action.

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blanket but going up and down."
*"The officer asked if it seems [seemed like] the sister was gratifying herself or the patient and the telesitter [observer] said the patient."
*The telesitter observer reported that the patient was just lying there, not responding.
*The telesitter observer notified the nursing staff and when they entered the room the behavior stopped.
*The sister said she was putting lotion on the patient's upper legs.
*The telesitter observer had not seen the sister using the lotion or massaging any other part of his body.
-She had seen the bottle of lotion but did not see the sister use it.
*The staff had been unable to contact the brother.
*Adult Protective Services (APS) was contacted and the Black Hills Advocate was able to obtain emergency guardianship of the patient on 11/29/23 at 4:00 p.m.
*The patient was moved to another room for safety.
*The sister was no longer able to have contact with the patient.

Interview on 11/30/23 at 8:00 a.m. with VP of quality and risk A regarding the above incident revealed:
*They had been in the process of attempting to discharge the patient under the guardianship of his sister.
*The staff had voiced concerns regarding his sister obtaining guardianship because of an incident that had occurred with the sister.
*They had found documentation in his chart on 9/8/23 from telesitter observer V regarding a concern of inappropriate touching of him by the sister.

A 115 VP Quality developed education related to the changes in Tiered Safety and Quality Huddle process and report script. Education will be completed by all inpatient and ED clinical leadership by February 8, 2024. Any inpatient or ED clinical leadership on leave will be required to complete education prior to first worked shift. Department director or designee will monitor education completion weekly and report to VP Quality, and respective department Vice Presidents monthly.

Monitoring:
Department leader or designee will visualize 100% of occupied beds per department, weekly for the use of 4 side rails. Medical records for those occupied beds identified as using 4 side-rails will be reviewed to ensure a provider order is present and the facility policy has been adhered to. Department leader or designee will continue to monitor until 100% compliance is achieved for 3 consecutive months. Department leader or designee will report results monthly to department VP and VP Quality. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

VP Quality or designee review charts of 5 patients in restraints per week to include **provider** documentation of benefits outweighing the risks, **documentation of less restrictive alternatives prior to restraint use,**

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*She stated:
-"What she told the police and what she documented are not the same."
-"She charted that a family member was touching him inappropriately in the private area but no further detail."
-"She told the police it looked like she was giving him a hand job and stopped when the staff entered the room."
-"She told his nurse and then it went no further."
-"The nursing staff didn't report it and yes they should have."
-"It is still under investigation and we sent a report to the DOH yesterday."
*Telesitter observer V was no longer employed with the provider and was not available for an interview.

Review of patient 15's EMR revealed:
*He:
-Had two admissions within a month of each other.
-Was admitted on 8/31/23 after a fall that resulted in multiple fractures to his right ankle and his right knee.
-Was discharged on 9/12/23 under the care of his brother and home health.
*On 10/11/23 he was readmitted for constipation.
*He:
-Exhibited behavioral and cognitive deficits stemming from fetal alcohol syndrome.
-Could follow simple commands and communicated through the use of gestures and one-word sentences.
*He was dependent upon the staff to:
-Ensure his plan of care was developed and implemented to meet his needs.
-Assist him with daily activities and care.
-Ensure his safety was maintained at all times.

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and compliance with restraint documentation of patient/family/guardian involvement. Monitoring will continue until 100% compliance is achieved for 3 consecutive months. VP Quality or designee will report results monthly to VP of Operations, **VP of Nursing**, Rapid City Market President, and **VP of Medical Affairs**. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee **and Medical Executive Committee.**

Monitoring:
Nursing Director of Clinical Coordination and Staffing or designee will visualize 100% of patients being monitored via telesitter 5 times per week to ensure privacy mode is initiated and removed appropriately. Nursing Director of Clinical Coordination and Staffing or designee will continue to monitor until 100% compliance is sustained for 3 consecutive months. Nursing Director of Clinical Coordination and Staffing or designee will report results monthly to the Vice President of Quality, Safety, Risk Management and the Vice President of Nursing. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

Monitoring
Nursing Director of Clinical Coordination and Staffing or designee will review 24 hours of documentation on 5 charts weekly for documented telesitter monitoring consent and telesitter

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*He was:
-Impulsive and had no boundary or safety awareness.
-At high risk for falls and a telesitter had been placed in his room for safety.
*Case management had been working on discharge placement into a long-term- care facility as the brother felt he could not take care of the patient any longer. His needs were greater than what he could assist him with.
*His sister was pursuing guardianship from the brother.

Interview on 12/4/23 at 2:15 p.m. with registered nurse (RN) G regarding patient 15 revealed:
*He:
-Was mentally delayed by fetal alcohol syndrome and was impulsive.
-Recently had a fall off a cliff that resulted in injuries that required surgical repair.
-Had only been over in that nursing area for a few days.
*She stated:
-"It's my understanding that there was some inappropriate actions between him and his sister."
-"That is why he was moved."
-"If for some reason she shows-up we are to call security immediately."
-"Visitors have to be approved through Black Hills Advocate first. They are his guardian now."

Observation and interview on 12/4/23 at 2:35 p.m. with nursing students W and X regarding patient 15 revealed:
*The room was dark, and the patient was lying on his bed sleeping.
*The top two side rails were in the up position and had been covered with protective pads.
*The two nursing students were in his room

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comments to ensure objective documentation and follow up occurred as indicated per policy. Nursing Director of Clinical Coordination and Staffing or designee will monitor until 100% compliance is sustained for 3 consecutive months. Nursing Director of Clinical Coordination and Staffing or designee will report results monthly to the Vice President of Quality, Safety, Risk Management and the Vice President of Nursing. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

Monitoring:
VP Quality or designee will monitor potential abuse or neglect concerns reported during Tiered Huddles 3 times per week and verify appropriate escalation and action has occurred. VP Quality or designee will continue to monitor until 100% compliance has been sustained for 3 consecutive months. VP Quality or designee will report results monthly to Rapid City Market President. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

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completing a shift change report.
*He:
-Required the use of one-to-one observation for his safety.
-Was mentally delayed and had no boundaries and safety awareness.
*His movements were quick and impulsive.
*He:
-Had a history of seizures and required padded side rails for his safety.
-Was not allowed visitors without permission and they were unsure as to why.

Review of patient 15's telesitter observer documentation from 9/1/23 through 9/12/23 revealed:
*On 9/8/23 at 4:29 p.m. the telesitter had documented "Family member touching pt. [patient] inappropriately in private area."
*The telesitter observer had called the caregiver at that time.
*On 9/10/23 at 2:29 p.m. the telesitter observer documented:
-"Sister on phone arguing with POA [power of attorney]."
-"Keeps trying to coax [patient's name] to say he wants to live w/her [with her]."
*On 9/10/23 at 9:29 p.m. the telesitter observer documented:
-"Family taking pic [pictures] of everything."
-"Trying to say we're not caring for her brother."

Review of patient 15's nursing end-of-shift notes from 9/1/23 through 9/12/23 revealed:
*There had been short summaries supporting his progress toward meeting his goals.
*No family concerns or issues were identified except that they had visited.
*There was no documentation to support that the

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floor nurse was aware of the concerns observed by the telesitter observers above.

Interview on 12/5/23 at 8:30 a.m. with nursing assistant (NA) I regarding patient 15 revealed:
*She stated:
-"I didn't work with him often but was told to watch him if the sister visited."
-"I was only told that there was some inappropriate actions between them."
-"So anytime she showed up I pulled the curtain and door open and sat at the computer across from his room so I could watch."
-"No one elaborated on what the inappropriate action was."
-"I don't know if it was reported but did find it weird they allowed her back in when knowing what she was doing to him."
-"I found out about it by another nursing assistant, not through huddle or management."
-"And now we started getting education on reporting, what sexual/inappropriate actions are or look like, and how to report it."

Interview on 12/5/23 at 9:07 a.m. with RN J regarding patient 15 revealed:
*She knew the patient quite well and had taken care of him on several occasions.
*He was mentally delayed and was at high risk for falls due to his impulsive behaviors and his poor safety awareness.
*There were times he required both a telesitter observer and a one-to-one for safety.
*She stated:
-"He didn't always listen to simple commands by the telesitter and that's why there was a staff person also."
-"Yes, I was working the day that the telesitter [observer] thought she saw the sister doing

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something inappropriate to him."
-"I was sitting at the computer across from his room."
-"The door was open but the curtain was drawn shut.
-"The telesitter [observer] called and said his sister was doing something inappropriate to him and it involved the hand."
-"She said the sister keeps lifting up the sheet."
-"I got up and went in his room and only saw the sister looking down at him."
-"I never saw her doing anything inappropriate with him."
-"Her daughter was there and usually came with her when she visited so I can't imagine she'd do anything with her there."
-"I asked if everything was okay and he looked calm and not in any distress."
-"I contacted the charge nurse and when she came up the sister had left."
-"There was a note posted to either stop her before she went in his room or watch her while she was there."
-"If we saw something happen we were to stop it, call the charge nurse, and doctor."
-"The charge nurses are the ones who report to the state."
-"But I honestly didn't see anything to report."
-"And I haven't worked with him since."

Interview on 12/5/23 at 9:48 a.m. with RN K regarding patient 15 revealed:
*She was one of the nurse managers on the unit that the patient had initially been admitted to.
*She was working the day that the telesitter observer called to report inappropriate actions seen between the patient and his sister.
*Charge registered nurse (CRN) DD had called her to report what the telesitter observer had

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reported to RN J.
*She stated:
-"I told her she needed to go see for herself and visit with the sister."
-"By the time (CRN DD's name) got back to me I was no longer at the hospital but was the manager on-call."
-"Apparently by the time she got down there the sister was gone and RN J didn't observe anything like what the telesitter [observer] explained to her."
-"And really lifting the sheets doesn't mean anything."
-"I've seen him pulling at sheets and his briefs."
-"Also what the telesitter [observer] documented was not what was reported to us."
-"Not sure when the document was reviewed because back then those documents were paper and had to be scanned in."
-"That process changed about a month ago and they [telesitter observers] can now document right into the chart for fast viewing."
*She was not sure what the timeframe looked like for getting the telesitter observers' documents scanned into the patients' charts.
-"When I returned to work I asked about the follow-up and since nothing was seen, there was nothing to report on."
-"I don't do any of the reporting, the CRN's do and it doesn't sound like there was anything to report."
-"I personally didn't check the documentation for that day, but I would expect the staff to have checked on him and assessed him to make sure he was okay and it sounds like that was done."
-"I wouldn't expect you to find a note or documentation from the nurse on the conversation because they couldn't substantiate it and the sister was gone by the time the CRN got there."

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*CRN DD was currently on a leave of absence and was not available for an interview.

Interview on 12/7/23 at 11:20 a.m. with RN P regarding patient 15 revealed:
*She was the lead for the case management team.
*She had not worked with patient 15 until his second hospitalization.
*They had been working on his discharge planning and the sister's having guardianship.
*To start that process she reviewed all of the documentation and notes from his first hospitalization.
-There was no documentation to support there was a concern about his relationship with his sister and possible abuse.
*At that time the telesitter observers' notes were scanned in and were not available for viewing.
*A patient safety report should have been completed if there had been any concerns identified with their relationship.
-There was no patient safety report completed from his first hospitalization.
*The staff voiced concerns to her about the sister and guardianship because of an incident that occurred with his first hospitalization.
*She stated:
-"This was so frustrating because even one of the doctors was concerned but thought it was just hearsay because she had never seen anything."
-"Apparently a telesitter [observer] reported that she saw the sister touching him inappropriately and called the nurse."
-"But there was no documentation anywhere in the chart to support that."
-"It was so frustrating because there was nothing available to even submit an APS report on."
-"That should have gone through mandatory

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reporting."
-"We have these length of stay meetings and apparently there was another recent incident during this stay."
-"On 11/27/23 his telesitter [observer] called the nurse because she saw the sister rubbing his back, rubbing his butt, and rubbing the back of his thighs."
-"So again, I checked the nurse's documentation from that incident and there was absolutely nothing in his chart to support anything inappropriate happened or was reported to the nurse."
-"I reviewed the telesitter's documentation and sure enough there it was."
-"In order to contact APS we needed further confirmation and documentation from his nurse."
-"We had her [the nurse] come in and make a late entry on what the telesitter [observer] reported to her and what she saw."
-"We had to scan in the previous telesitter [observer] information and with law enforcement interviews, legal support, and performance engineer C's assistance we were able to complete an APS report so the sister couldn't have guardianship."
-"Black Hills Advocate has full custody of him now and the sister is not to have any contact."
*She:
-Was not aware that the SD DOH did not know about the second incident that had recently occurred while on survey.
-Agreed SD DOH should have been made aware of the second incident when informed of the first incident.
-Stated:
--"To me, that should have been reported right along with the first incident. It's part of the APS report for supporting evidence."

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--"Because of the word inappropriate, I would have considered this a reportable event."

Interview on 12/7/23 at 1:50 p.m. with RN Q regarding patient 15 revealed:
*She did not work with the patient until his second hospitalization.
*She had initially been told that something occurred between him and his sister with his first hospitalization.
*She had not been:
-Given any specifics on what had occurred.
-Informed that he needed supervision when the sister visited.
*On 11/27/23 she received a call from the telesitter observer that she had seen the sister touching him inappropriately.
*The floor nurses were in the middle of shift report so she checked on them herself.
*She stated:
-"I didn't see anything inappropriate going on."
-"He had a posey bed [mesh enclosed bed] and it was unzipped already and I saw her rub his back and then touch his hand."
-"I stayed with them until she left and I never witnessed anything inappropriate."
-"I called the telesitter [observer] to see what exactly she saw."
-"She said well I thought I saw her touch his back, bottom, and back of his legs."
-"I told her to document fully what she saw."
-"I reported it to the oncoming CRN who then reported it to case management who then told leadership I guess."
-"I didn't think it was a reportable event because I didn't witness anything bad happen."
-"I had to come in and do a late note on it and then I received a text message and email to report events like this."

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*She confirmed:
-Inappropriate touching between patient and staff or patient and family was a reportable event.
-She should have reported it.
*She stated: "With the education we've received I'll immediately call the managers with anything like this."

Interview on 12/7/23 at 2:30 p.m. with Nursing assistant (NA)/telesitter observer R regarding revealed:
*She had been a telesitter observer for seven to eight years.
*She confirmed:
-They were required to call the nurse when they witnessed any type of abuse to a patient.
-She recently observed a situation where a patient was being inappropriately touched by his sister.
*She stated:
-"The patient's sister had a history of inappropriately touching him."
-"She was touching his buttocks and the back of his legs."
-"He didn't look in any distress but then he's not mentally capable of knowing if something is right or wrong."
-"I was not told what happened after that, but shortly afterward the family was banned from seeing him and all visitors had to be approved first."
-"We did just recently have education on witnessing abuse and what to do."
-"We did get a policy that we can scan and use as a reference now too."

Review of patient 15's 11/27/23 at 6:30 p.m. the telesitter observer documentation revealed:
*Observation: "I called 9th [floor] CRN, family was

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touching pt [patient] inappropriately on the buttocks and back of leg of patient."
*The patient was in bed, awake, and the caregiver was called.

Review of patient 15's 11/28/23 late entry nursing note by RN Q revealed:
*"This CRN was notified by telesitter staff at approximately 1905 [7:05 p.m.] that patient's sister was currently in patient's room, and was touching patient inappropriately. I went to the bedside to find the dayshift RN and nightshift RN doing bedside report in the doorway. The posey bed was currently unzipped slightly by dayshift RN so visitors can hold patient's hand to help sooth patient. I notified them of the phone call I received, and asked if they noticed any inappropriate behavior since they were 10 feet from the patient."
-"They replied that they had not. I then entered the room and introduced myself to the patient's sister (her daughter was also in the room at this time). I discussed with them that since the patient is in a posey bed we need to have a staff member sitting in the patient's room if we unzip the bed for visitors. Both verbalized understanding of this, but stated some frustration that it seems to take a while to find a staff member to sit, and by the time a sitter is available visiting hours are over. I stated I would gladly sit with them until visiting hours are over at 1930 [7:30 p.m.]."
-"Both the sister and her daughter stated understanding of this, and thanked me. As I sat in the room, I did witness the patient's sister rub the patient's back and hold his hand. Her daughter also gave the patient a few hugs before leaving. I don't feel that I witnessed any inappropriate touching by either family member as I sat in the room with them."

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-"I called the telesitter staff back and asked specifically what they saw. They stated that his sister was rubbing his back, and then rubbed his buttocks, and the back of his legs. I asked the telesitter staff to document this specifically in the telesitter observation charting. telesitter staff verbalized understanding of this."

Interview on 12/7/23 at 1:40 pm. with performance engineer C revealed:
*VP of quality and risk A, director of quality, safety, and risk B, and herself was the team that would have reviewed the incident reports.
*When filling out an incident report, the staff had the capability to select which leadership department that the report should go to for review.
-They would not always receive a copy of the report unless staff had selected them to review it.
*Not every report was reviewed as a team with VP of quality & Risk A, director of quality, safety, and risk B, and herself.
-They could have reviewed a report and made a decision whether to report it or not without meeting with each other.
*She was aware there had been two separate incidents identified by a telesitter observer where they had documented inappropriate touching of patient 15 by his sister.
*She confirmed they had reported the first incident to the SD DOH but not the second one for suspicion of abuse by the sister.
*She stated:
-"Inappropriate is a vague word and touching or rubbing can be considered soothing to some people, even their bottom."
-"The nurse had not seen anything inappropriate happening between them and he was not in any distress."

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-"Because of that, no I do not feel it needed to be reported."
*She offered no further comment to support the following:
-Why it was important to have RN Q put in a late entry in his chart specific to the second incident.
-Why it was important for APS to be aware of both those incidents for suspicion of sexual abuse by the sister but not the SD DOH.
*She had confirmed the first incident should have been reported right away to the VP of quality and risk, director of quality, safety, and risk, and herself for review and follow-up for everyone's awareness and his safety.

Interview on 12/8/23 at 10:00 a.m. with VP of quality and risk A and director of quality, safety, and risk B regarding patient 15 revealed that the staff should have reported the incidents right away to ensure the safety of the patient from any further potential abuse and neglect from his sister.

Review of the provider's September 2023 Reportable policy revealed:
*Mandatory Report:
-"Any incident or event where there is reasonable suspicion of abuse or neglect of any hospital patient by any person shall be reported within 24 hours of becoming informed of the alleged incident or event."
-"An investigation will begin immediately and a written report will be submitted to the Department of Health within 5 working days after the event (SD Admin Rule 44:75:01:07)."

Review of the provider's February 2021 Suspected Abuse or Neglect of Elderly or Disabled Adults revealed:

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A 115	Continued From page 20 *"Hospital personnel may become aware of the abuse, neglect or exploitation of disabled or elderly adults who are patients." *"Reporting of suspected cased of abuse, neglect or exploitation of disabled or elderly adults is mandatory for ....nurses.....any health care professional......" *"If staff know or have reasonable cause to suspect an elder or disabled adult has been or is being abused or neglected, then it must be reported within 24 hours." Review of the provider's February 2022 Patient Rights & Responsibilities policy included the following: "Patient rights. Provision of care in a safe setting and freedom from all forms of abuse or harassment." 2. Through interviews, observations, and policy review, the provider failed to identify a concern for patient privacy and dignity while using a telesitter in the patients' rooms. *When a patient had been identified as a high risk for self-harm, falls, and elopement a telesitter was placed inside of their room so staff could continuously observe them. *The telesitter was a tall mobile device that had a large camera at the top of it for video monitoring of those patients. -Staff could view patients at all times with the use of the telesitter. *Through observations it was identified that: -The telesitter observer were located in a different area of the hospital other than the patients' area and had no direct patient contact. -There were two monitors that could have up to 12 patients at a time on it during the observation and monitoring process. -The telesitter observer could to talk to the patient	A 115		

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A 115	Continued From page 21 and give simple commands when their safety was a concern. -The telesitter had an alarm capability should the patient not listen to the simple command. -The telesitter could have been shut-down by the observer when the privacy and dignity of the patient were a concern. *Through interviews it was identified: -There was no formal policy and process for the use of the telesitter until a policy was requested for review by the surveyor. -The direct caregivers could not remotely shut-down the telesitter during personal care or when privacy was a concern. *Refer to A143, Findings 1 and 2. 3. Through observations, interviews, document review, and policy review, the provider failed to identify a concern with the following: *The staff had the capability to use all four side rails on a patient's bed without the involvement of a physician when the patient was identified as a high fall risk. *The family had the capability to request the use of all four side rails to be used for the patient without providing education, a physician's order, or the completion of a safety assessment. *No requirement for a written informed consent form by the patient or designated guardian prior to the use of the side rails. *Using all four side rails, four or two point restraints, chemical restraints, and bed alarms simultaneously for patient safety. *Refer to A154, Finding 1 through 7.	A 115		
A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy.	A 143	Legal Counsel, VP Quality, VP Nursing, Nursing Practice Consultant, Performance Engineer discussed options for obtaining documented consent for the use of telesitter monirtoring. Consent for	02/08/24

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This STANDARD is not met as evidenced by:
Based on observation, interview, electronic medical record review (EMR), and policy review, the provider failed to ensure the following:
*Privacy and dignity were maintained during the use of a two-way video monitoring system (telesitter) for two of two sampled patients (14 and 19) while they received personal care from the direct caregiver staff.
*A policy and procedure was in place for the use of the telesitter monitoring system.
Findings include:

1. Observation on 12/4/23 at 1:39 p.m. with certified nursing assistant (CNA)/telesitter observer EE revealed:
*He had been sitting at a desk monitoring multiple patients at one time while they were in their rooms through a two-way video monitoring camera.
*He had the capability of talking to the patients and could give them simple commands through the system if they had:
-Attempted to get out of bed without staff assistance.
-Attempted to leave their room without staff assistance or knowledge.
-Been unsafe or were at risk of injury.
*If the patients could not follow his command he would have called the floor nurse.
*While observing the monitoring system in use, it was identified that patient 14 had been:
-Laying in her bed and receiving assistance from two caregivers.
-The patient's gown was pulled up to her abdomen and the staff had been applying an incontinent brief on her.
-The telesitter observer continued to monitor her

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Treatment document was reviewed and revised to include the addition of continuous audio/video monitoring, calling out specifically telesitter monitoring.

Policy Remote Sitter/Tele sitter was reviewed and revised by VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing. Revisions include the addition of process when privacy mode is needed or requested and when patient view can be re-instated.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing reviewed and revised electronic telesitter documentation to include the option to document action taken related to observations. Nursing Professional Development created a tip sheet for telesitters related to nurse aides charting objective documentation.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing developed education to include privacy mode process, documentation of observations and escalation process, and telesitter monitoring consent. Education will be completed by all nurse aides who function as a telesitter by February 8, 2024. Caregivers on leave must complete education before the first worked shift. Nursing Director of Clinical Coordination and Staffing or designee will monitor

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while the staff assisted the patient with personal care.
*The telesitter observer had the capability of turning down the monitor so he could not view the patients.
-The direct caregivers did not have that capability and would have had to call the telesitter observer before they assisted patients with personal care.
-He confirmed there could have been times where the staff would not have always been able to do that prior to assisting those patients.
*He confirmed:
-The staff would have had to leave the room to call him.
-There were times when the staff could not leave the patient to call him before assisting a patient with personal care.
*He demonstrated how he could turn the camera down or off but then turned it back on so we could see the patient receiving personal care.

2. Observation on 11/29/23 at 4:00 p.m. of patient 19 who had the use of a telesitter revealed the patient had received personal care while the nurse aide/telesitter observer had been monitoring the patient.

Interview on 12/4/23 at 1:52 p.m. with registered nurse (RN) F regarding the use of the telesitter revealed:
*She was the float pool nursing and the director of the nurse aide/ telesitter observers.
*A physician's order was not required to use the telesitter.
*Nurses were able to use their clinical judgement to initiate the use of a telesitter.
*She confirmed:
-There was a process for the telesitter in the Suicide policy but not a specific one for the staff

A 143 education completion weekly. Nursing Director of Clinical Coordination and Staffing or designee will report results monthly to the Vice President of Quality and the Vice President of Operations.

VP Quality, VP Nursing, Nursing Consultant, and Nursing Director of Clinical Coordination and Staffing developed education to include privacy mode process, and telesitter monitoring consent. Education will be completed by all patient facing providers and caregivers by February 8, 2024. Caregivers and providers on leave must complete education before the first worked shift. Department Director or designee will monitor education completion weekly. Department Director or designee will report results monthly to the Vice President of Quality and the Vice President of Operations.

Human Resources, Nurse Practice Consultant, VP of Quality, and Nursing Director of Clinical Coordination and Staffing reviewed and revised the nurse aide job description. Changes to the description included the addition of the essential functions of telesitter while maintaining privacy and dignity when utilizing electronic monitoring. Nursing Director of Clinical Coordination and Staffing updated telesitter competency to include essential job functions and orientation checklist. Staff performing telesitter monitoring duties will complete this competency before anyone is

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policy and procedure to follow on the use of the telesitter.
-The policy had been in draft form since 11/29/23 and it was just approved by the governing body for use.
*She agreed there could have been patient privacy and dignity issues with the use of the telesitter.
*She stated: "But they are all CNAs or NAs and they are bound by the HIPPA requirements like everyone else."
*She agreed the telesitter should have been repositioned for privacy while patients were receiving personal care.

Interview on 12/5/23 at 10:45 a.m. with nurse manager K regarding the telesitter observer and the potential for the employee who could observe staff providing personal care to the patient's on the camera revealed:
*The telesitter observer could observe the staff performing patient personal care.
*The camera had the capability of being repositioned during those times by the telesitter observer but not the direct caregivers.
*Agreed that the telesitter could have been a privacy and dignity issues for patients.
*She stated:
-"But the cameras are just live streamed and not recorded."
-"Those are trained staff and bound to the privacy rule too."
-"But yes, it could be a privacy dignity issue for the patients if the camera is not turned down during those times."

Interview on 12/7/23 at 2:30 p.m. with nurse aide/telesitter observer R regarding the use of a telesitter revealed she:

A 143 (Plan of Correction)
deemed independent in the telesitter position. Telesitter competency was completed by all nursing aide staff who perform telesitter monitoring by February 8, 2024.

Human Resources, Nurse Practice Consultant, VP of Quality, and Nursing Director of Clinical Coordination and Staffing developed education to reflect the changes to the essential functions in the nurse aide job description. Education will be completed by all nurse aides who provide the telesitter function by February 8, 2024. Caregivers on leave must complete education before the first worked shift. Department Director or designee will monitor education completion weekly and report to the Vice President of Quality and the Vice President of Operations monthly.

Monitoring
Nursing Director of Clinical Coordination and Staffing or designee will review 24 hours of documentation on 5 charts weekly for documented telesitter monitoring consent and telesitter comments to ensure objective documentation and follow up occurred as indicated per policy. Nursing Director of Clinical Coordination and Staffing or designee will monitor until 100% compliance is sustained for 3 consecutive months. Nursing Director of Clinical Coordination and Staffing or designee will report results monthly to the Vice President of Quality, Safety, Risk

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*Had been a telesitte observer for seven or eight years.
*Would have put the camera in privacy mode while patients were receiving personal care.
-She would have informed the staff that she was going into privacy mode and to let her know when they completed personal cares for the patient.
*She could speak to the staff and inform them that she had turned the camera back on for observation or off for privacy.
*She stated:
-"We are required to go into privacy mode when a patient is having anything done that is a privacy concern and that has always been in place."
-"There is a privacy mode on every camera that we can use and we should if privacy is a concern."

On 12/4/23 at 10:00 a.m. the observations and interviews above were reviewed with the vice president of quality and risk A and director of qualtity, safety, and risk RN B. They were not aware of the privacy and dignity concern above with the use of the telesitters. They agreed the telesitter should have been shut-down while the patients received personal care.

Review of the provider's September 2023 job description for a nurse aide/telesitter observer revealed:
*"A Nurse Aide will assist the nursing staff in providing excellent, effective and safe patient care, be responsible for providing patient personal care, bathing, and personal hygiene."
*"You will participate in admission and dismissal also the transfer process and contribute to the permanent documentation of patient data."
*"Essential Functions:"
-"As a member of the multidisciplinary team, the

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Management and the Vice President of Nursing. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

Nursing Director of Clinical Coordination and Staffing or designee will visualize 100% of patients being monitored via telesitter 5 times per week to ensure privacy mode is initiated and removed appropriately. Nursing Director of Clinical Coordination and Staffing or designee wil continue to monitor until 100% compliance is sustained for 3 consecutive months. Nursing Director of Clinical Coordination and Staffing or designee will report results monthly to the Vice President of Quality, Safety, Risk Management and the Vice President of Nursing. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

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A 143	Continued From page 26 Nurse Aide contributes valuable input to the patient's care planning process." -"Completes documentation accurately and in a timely manner according to policies, procedures, and regulations." -"Recognizes and reports changes in the patient's condition and encourages the patient to participate in their own activities of daily living and plan of care as appropriate." *There was nothing in the job description regarding the role and responsibilities of the telesitter observers. Review of the provider's February 2022 Patient Rights & Responsibilities policy revealed: "Personal privacy was a patients right." Review of the provider's 11/29/23 Remote Sitter: Telesitter (Draft Policy) revealed the nursing staff were responsible to notify the monitoring station if patient privacy is needed i.e.: bedpan, physician visit, clergy visit, etc. Review of the providers 12/2023 Remote Sitter/Telesitter policy revealed: *"All caregivers involved in the remote monitor process will provide patient privacy/confidentiality as indicated unless safety is compromised." *"Nursing staff were to notify the remote sitter monitoring station if patient privacy was needed."	A 143		
A 154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of	A 154	VP Quality, VP Nursing, Nursing Practice Consultant, and Mobility Safety team leads reviewed Restraint and Seclusion Use Policy, Fall prevention program policy, Federal and State regulations related to restraint use. Revisions to the Restraint and Seclusion policy include: added possible risks of using restraints, the use of 4 side rails is considered a	02/08/24

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coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

This STANDARD is not met as evidenced by:
Based on observation, interview, electronic medical record (EMR) review, and policy review, the provider failed to ensure:
*Physician involvement when four side rails were used as a restraint for one of one sampled patient (15) who were assessed as a high fall risk or per family request.
*Family or patient guardians were educated on the risks and benefits for one of one sampled patient (18) the use of four side rails.
*Physician's order were required to support the use of a restraint for three of three sampled patients (8, 2, and 19) that prevented them from voluntarily getting out of bed.
*Written informed consent forms were obtained from the patient or designated guardian before the use of a restraint.
*Documentation was in place to support the benefits outweighed the risks of using multiple restraints simultaneously for one of one sampled patient (17).
*Policies and procedures were in place for the use of multiple restraints simultaneously such as side rails, bed alarms, two or four point restraints, and chemicals to ensure the safety for two of two sampled patients (17 and 14).
Findings include:

1. Review of patient 8's EMR revealed she:
*Was admitted to the rehab unit on 8/25/23.
*Had been diagnosed with a subarachnoid hemorrhage (bleeding in the space between the

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restraint and can only be used when ordered by a provider unless a stated exception exists and restraint documentation must be completed to include patient/surrogate education. Clarified in policy that patient/family/ surrogate request for the use of 4 side rails is also considered a restraint, clarified handcuffs are not a restraint but are a forensic or correction restriction, added the use of multiple restraints simultaneously must include orders for each restraint type, and added Telesitter Monitoring as an alternative to restraint/ seclusion. Removed from policy Fall Prevention Program is the exception of using 4 side rails to protect the patient from falling out of bed in the adult care areas.

Restraint and Seclusion policy was updated to include exceptions for the use of 4 side rails as a restraint as outlined by CMS A-0154 interpretive guidelines and State regulation 44:75:04:12 including: recovery from anesthesia, seizure precautions, side rails on a stretcher, during transport, patients receiving continuous IV sedation, certain types of therapeutic beds, and side rails used for age or developmentally appropriate pediatric patients.

VP Quality, VP Nursing, Nursing Practice Consultant, ICU Medical Director, and Medical Director Hospital Medicine and IT Application Analyst reviewed provider restraint order, and provider

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brain and tissue covering the brain) and an aneurysm (a ballooning and weakened area in an artery).
*Had been identified as a high risk for falls which required the fall bundle and the high-risk bundle implementation.
*Sustained a fall on 10/30/23 at 7:00 p.m. while attempting to get out of bed without assistance.
*Had all four side rails in the elevated position on her bed on 10/31/23 at 7:00 a.m. after her fall.
-There was no documentation that a physician's order was obtained for the use of the four side rails.

2. Review of patient 2's EMR revealed he:
*Had been admitted on 9/29/23 to the oncology unit.
*Had been diagnosed with a Glioblastoma (a type of cancer that starts as a growth of cell in the brain and spinal cord) and elevated bilirubin (a yellowish substance made during your body's normal process of breaking down old red blood cells)
*Had a physician's order identifying him as a fall risk and seizure precautions.
*Had a fall with a fracture to his left third rib on 10/3/23 at 3:30 a.m.
*Had documentation that four side rails were in the elevated position on the following days:
-10/1/23 at 7:00 p.m.
-10/3/23 at 10:27 a.m.
-There was no physician's order for the four side rails to have been implemented.
*Had documentation that all four side rails had been padded and in the elevated position on the following days:
-10/6/23 at 8:00 p.m.
-10/7/23 at 8:00 a.m.
-10/8/23 at 9:00 p.m.

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documentation regarding **risks and benefits for multiple use of restraints and documentation of least restrictive measures prior to restraint use.** Order updated to allow for the documentation of benefits outweigh the risks when using 4 side rails and multiple restraints simultaneously.

Legal Counsel, VP Quality, VP Nursing, Nursing Practice Consultant, and Performance Engineer reviewed and revised Consent to Treatment and Conditions of Admission to include consent for the use of restraints per Restraint and Seclusion Use Policy.

VP Quality, VP Nursing, Nursing Practice Consultant, and Mobility Safety team leads developed education to include **documentation of less restrictive alternatives prior to restraint use, benefits outweighing the risks documented by the provider when ordering single or multiple types of restraints simultaneously,** restraint consent as part of Consent to Treatment and Conditions of Admission, Restraint and Seclusion and Fall Prevention policy revisions. Education will be completed by medical staff, nursing, nursing assistants, paramedics, ED techs, PT, OT, ST, PT/OT/ST techs, imaging, patient transport, phlebotomists, respiratory therapy, transport, food and nutrition and medical staff by February 8, 2024. Caregivers and providers on leave will be required to complete education prior to the first

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3. Review of patient 17's EMR revealed he:
*Was admitted on 9/29/23 and was discharged on 10/2/23.
*Was diagnosed with confusion, altered mental status, and possible drug intoxication.
*Was under the custody of law enforcement which required a guard to be at his bedside and handcuffs to his wrists and ankles at all times.
*Had a physician's order placed on 9/29/23 at 10:11 p.m. for nonviolent four point soft restraints in addition to his wrist and ankle cuffs.
-The criteria had been explained to the patient with the verbalization from the patient that he understood the need for those restraints.
-There was documentation of less a restrictive alternatives to include assessment for pain and medication administration, decrease the stimulus to the patient, and a police officer at his bedside.
-Four-point restraint documentation was identified on the following days:
9/30/23 at 7:04 a.m.
-The physician order was discontinued on 10/1/23 at 11:06 a.m.
-Was transferred to the intensive care unit on 9/30/23 at 4:30 a.m. with a Precedex drip (a medication used during surgery and other medical procedures to cause a loss of consciousness).
-There had been increased safety concerns (combativeness) for the patient and the staff that required the use of that medication.
-The physician's order was discontinued on 10/2/23 at 1:02 p.m.
*Had documentation of all four side rails in the elevated position on the following days:
-9/30/23 at 7:00 a.m.
-9/30/23 at 8:00 p.m.
-10/1/23 at 7:00 a.m.

A 154 worked shift. Department director or designee will monitor education completion weekly and report to VP Quality and VP of Operations monthly.

Monitoring:
Department leader or designee will visualize 100% of occupied beds per department, weekly for the use of 4 side rails. Medical records for those occupied beds identified as using 4 side-rails will be reviewed to ensure a provider order is present and the facility policy has been adhered to. Department leader or designee will continue to monitor until 100% compliance is achieved for 3 consecutive months. Department leader or designee will report results monthly to department VP and VP Quality. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

VP Quality or designee review charts of 5 patients in restraints per week to include **provider** documentation of benefits outweighing the risks, **documentation of less restrictive alternatives prior to restraint use,** and compliance with restraint documentation of patient/family/guardian involvement. Monitoring will continue until 100% compliance is achieved for 3 consecutive months. VP Quality or designee will report results monthly to VP of Operations, **VP of Nursing,** Rapid City Market President, and **VP of Medical Affairs.** VP Quality or

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-10/1/23 at 8:00 p.m.
-There was no documentation that a physician's order was obtained all four side rails to have been elevated.
*There was no documentation to support:
-For a physician's order to support the use of all four types of restraints simultaneously.
-On how the benefits outweighed the risks of using multiple restraints simultaneously including chemical restraint.

Interview on 11/29/23 at 11:00 a.m. with nurse manager CC regarding the use of all four side rails revealed:
*Only two side rails were to have been used and that was part of their fall bundle.
*Four side rails would have been considered a restraint, if there was a need for all four side rails to be elevated a physician's order would have been obtained and a constant observer would have been utilized.

4. Observation on 12/4/23 at 1:40 p.m. of patient 14 via the two-way camera monitoring system (telesitter) revealed she had been placed in four-point restraints with all four side rails elevated.

Review of patient 14's EMR revealed she had:
*Been admitted on 11/30/23 and was discharged on 12/5/23.
*Been diagnosed with altered mental status and Alzheimer's disease.
*A physician's order was obtained for two-point restraints on 12/1/23 at 8:33 p.m.
*A physician's order was obtained to use four-point restraints on 12/2/23 at 3:43 p.m. until the order was discontinued on 12/5/23.
*There was no documentation to support the

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following:
-A physician's order for all four side rails to have been used simultaneously with the four-point restraints.
-How the risks outweigh the benefits of using multiple restraints at the same time.

Interview on 12/4/23 at 2:15 p.m. with RN G revealed:
*A physician's order was required when all four side rails were elevated on a patient's bed.
*She was not sure when a physician's order was required when the family requested the use of all four side rails for the patient.

Interview on 12/4/23 at 2:28 p.m. with RN H revealed:
*He confirmed that a physician's order was required when a patient was using all four side rails on their bed.
*A family member could have requested the use of all four side rails for a patient.
-A physician's order would not have been required for a family request to use all four side rails.

5. Observation on 12/5/23 at 11:30 a.m. of patient 18 revealed:
*She was lying in bed with the privacy curtain pulled to the middle of her bed.
*All four side rails were elevated on her bed.

Interview on 12/5/23 following the above observation with RN AA revealed:
*Patient 18's family requested the use of all four side rails while she was in bed.
*She stated that if a patient's family requested that all four side rails be used she did not need a physician's order.
*If she raised all four of the side rails, she would

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need a physician's order because that would have been considered a restraint.

6. Observation and interview on 12/5/23 at 11:40 a.m. with nurse aide (NA) M revealed:
*She was completing a one-to-one observation with patient 15.
*The patient had been lying in bed with all four side rails in the elevated position.
*She stated:
-"I put them up because his feet keep going over the side of the bed."
-"Generally it would have come from the nurse but if we feel a patient is unsafe, we can put them up for a little bit."
-"But now that he is knocked out it's okay to put them back down."

Interview on 12/5/23 at 11:42 a.m. with RN G regarding the observation above revealed:
*She was unaware that NA M had put all four of the patient's side rails in the elevated position.
*She stated:
-"He is not supposed to have all of those up, only the top 2."
-"They can't just put them up like that, that is a restraint then and we need an order."

7. Observation on 12/5/23 at noon of patient 19 revealed:
*She was lying in bed with the privacy curtain pulled to the middle of her bed.
*All four of her side rails were in the elevated position.

Interview on 12/5/23 following the above observation with RN BB revealed:
*Patient 19 had her soft restraints removed at 8:00 a.m.

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*He was unsure if there was a physician's order for all four side rails to have been in the elevated position.
*He had reviewed the patient's physician orders and confirmed there was not a physician's order for all four side rails to have been in the elevated position.

Interview on 12/5/23 at 10:45 a.m. with nurse manager K regarding the use of all four side rails and four-point restraints revealed if hand and ankle restraints were used there would have been no need to use all four side rails.

Interview on 12/7/23 at 3:50 p.m. with nurse clinician S regarding the use of all four side rails revealed:
*She would have provided education to newly hired and temporary agency staff regarding the use of side rails with fall prevention education.
*Patient safety regarding falls and nurse's clinical judgement would have dictated the number of side rails to have been used while caring for that patient.
*The bed alarm would have been used at the same time with all four side rails in the elevated position.
-That would allow more time for staff to respond to the bed alarm before the patient exited the bed.
*All four side rails being used was not considered a restraint based on the fall policy.
*If a patient was identified as high risk for falls, that would not automatically dictate the use of all four side rails.

Interview on 12/8/23 at 8:15 a.m. with performance engineer C regarding patient 17 and the use of hand and ankle cuffs, four-point

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restraints, the Precedex drip, and the use of all four side rails elevated revealed that the use of all the restraints simultaneously was appropriate.

Review of the provider's December 2022 Restraint and Seclusion Use policy revealed:
*"The goal is to prevent, reduce, or eliminate, when possible, restraint and seclusion. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of convenience."
*"Acute non-violent/non-destructive restraint is any restraint use to prevent inadvertent disruption of treatment."
*"Licensed Independent Practitioner (LIP) is any licensed healthcare professional with medical staff privileges who by state law can evaluate and order restraints. These include physicians, medical residents, physician assistants, nurse practitioners, and house officers."
*"Chemical restraints as defined is a medication when used as a restriction to manage the patient's behavior or restrict the patient's freedom or movement and is not a standard treatment or dosage for the patient's condition. Drugs or medication are not a restraint when used as part of the patient's standard medical or psychiatric treatment, and are administered within the standard dose for the patient's medical condition."
*"Examples of Physical Restraints-less restrictive method utilized first.
-Side rails when used for the purpose of restricting movement."
*"Side rails are not considered a restraint if used to protect the patient from falling out of bed."
*No documentation or guidance to guide the staff on:
-How to document the supported use of multiple restraints simultaneously.

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A 154	Continued From page 35 -How the risks outweigh the benefits of using multiple restraints simultaneously.	A 154		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: A Based on a review of the South Dakota Department of Health (SD DOH) complaint intake information, observations, interviews, and policy reviews, the provider failed to implement interventions promptly to prevent pressure ulcers from developing and worsening while under their care for three of three sampled patients (1, 9, and 10). Findings include: 1. Review of the 8/9/23 incident report submitted to the SD DOH for the allegation of neglect for patient 1 while she received care and services as an inpatient at the hospital from 7/1/23 through 8/2/23 revealed: *The patient was not capable of providing an explanation of the event or participating in the investigation. *Explanation of the event and concerns being reported were: -"Patient 1, resident had a skin evaluation completed on 6/28/23 while residing at [facility name] that revealed no impaired skin integrity. Patient 1 was admitted to the hospital on 7/1/23 with no pressure injuries, she started to have skin break down during her stay at [hospital name] on 7/5/23, with 7 pressure injuries noted. To include (6 DTI's [deep tissue injuries], 1 unstageable and	A 385	VP Nursing, Nurse Practice Consultant, Hospital Acquired Pressure Injury Team, Performance Engineer, Wound Care Clinical Quality Coordinator and VP Quality reviewed the policy Skin Assessment: Prevention, Treatment, Reassessment, and Documentation. Policy updated to include processes for pressure injury/wound assessment documentation on patient admission and transfer (4 eyes in 4 hours process), early initiation of pressure injury prevention interventions, wound care treatment options available to the bedside nurse, and treating and documenting care of wounds sustained from restraints or hand cuffs. VP Nursing, Nurse Practice Consultant, Hospital Acquired Pressure Injury Team, Performance Engineer, Wound Care Clinical Quality Coordinator, VP Quality, and EPIC Analyst reviewed current nursing workflow related to integumentary assessment and intervention. EPIC analyst made the following changes in electronic medical record: best practice alert for 4 eyes in 4 hours was modified, links to early intervention/prevention were added to row information, the Bedside Mobility Assessment Tool (BMAT) score was moved closer to the Braden score to further identify patients at risk of skin breakdown and turning reminders are	02/08/24

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1 Stage 4 [full thickness tissue loss with exposed bone, tendon, or muscle]. Upon her return [facility name] on 8/2/23 she was noted to have a Stage 4 to sacrum with inadequate dressing applied. Also noted to have an unstageable pressure ulcer to her spinal area covered with a Lidoderm patch [medicated patch typically used for pain management]. After speaking with the family and our medical director it was decided to report hospital for neglect due to skin condition upon re-admitting to [facility name]."

Review of patient 1's 8/2/23 electronic medical record (EMR) with performance engineer C revealed:
*She was admitted on 7/1/23 through the emergency department (ED) for a ground level fall with complaints of back pain and inability to ambulate.
*Her diagnoses included the following: acute midline thoracic pain, anemia, dialysis related to chronic kidney disease, history of stroke, Dementia, a history of falls, and hyponatremia.
*Skin assessment in the ED revealed the following:
-The assessment was completed by two nurses.
-The documentation indicated no wounds to her skin except for a small bruise on her left upper arm.
-She was identified as a low risk for pressure ulcers or skin breakdown.
*The physical exam in the ED noted what appeared to have been a deformity of her thoracic area and a possible soft tissue injury.
*A CAT Scan [imaging equipment] was completed to rule out injury versus osteomyelitis.
*On 7/2/23 she was admitted to the hospital.
-Her initial skin assessment was completed by two nurses and no skin problems were

A 385 triggered based on those scores.

Wound Care Clinical Quality Coordinator, VP Nursing, Nurse Practice Consultant, Hospital Acquired Pressure Injury Team, Performance Engineer, and VP Quality developed education to emphasize pressure injury prevention interventions, initial wound assessment and documentation on admission and transfer requirements, early initiation of wound care by inpatient nurse, and appropriate care and documentation of wounds sustained from restraints or hand cuffs. Education will be completed by all inpatient nurses by February 8, 2024. Nurses on leave will be required to complete education prior to the first worked shift. Department Director or designee will monitor education completion weekly. Department Director or designee will report results to the Vice President of Quality, Safety, Risk Management and the Vice President of Nursing monthly.

Wound Care Clinical Quality Coordinator, VP Nursing, Nurse Practice Consultant, Hospital Acquired Pressure Injury Team, Performance Engineer, and VP Quality developed education for inpatient patient facing providers related to timely documentation of wounds. Education will be completed by all inpatient patient facing providers by February 8, 2024. Physicians and practitioners on leave will be required to complete education prior to the first worked shift. Department

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documented.
*Neurosurgery was consulted and on 7/3/23 due to limb weakness was taken to the operating room with an exploratory procedure completed to confirm vertebral osteomyelitis with disc removal in her thoracic area at the same time.
-Prior to her surgical procedure her skin was assessed by two nursing staff with no concerns documented.
*Bone cultures completed which were positive for infection.
-Antibiotic therapy was initiated.
-Her Permacath was identified as the source for the infection and had been removed.
*On 7/4/23:
-She was admitted to the orthopedic/neurological/surgical floor.
-A skin assessment was completed and a Stage 2 pressure ulcer was found on her coccyx and a consult for wound care was ordered.
-The nursing staff documented that the wound was pre-existing.
-She developed decreased strength and weakness to her left leg and was diagnosed with a stroke.
-Palliative care was notified and through a consultation with her son the code status was changed to do not resuscitate.
*On 7/5/23:
-Her skin was assessed by the wound care team with multiple DTI wounds identified during their assessment.
-A specialty low air loss bed was ordered and initiated.
*She had poor memory recall and was unable to participate in decision making for her care.
*She was dependent upon the staff for:
-The development of her plan of care and to ensure the interventions were implemented for

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Director or designee will monitor education completion weekly.
Department Director or designee will report results to the Vice President of Quality, Safety, Risk Management and the VP Medical Affairs monthly.

Monitoring
Inpatient Department Director or designee will review 5 inpatient charts per week, per department to ensure the following occurred: admission and transfer skin assessment completion, early initiation of preventative measures, initiation of wound care measures by bedside nurse prior to wound care team consult, and documentation. Monitoring will continue until 100% compliance is sustained for 3 consecutive months.
Inpatient Department Director or designee will report results monthly to the Vice President of Quality, Safety, Risk Management and the Vice President of Operations. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

VP Quality or designee will monitor 20 charts per month to ensure timely provider documentation of wound presence. Monitoring will continue until 100% compliance is sustained for 3 consecutive months. VP Quality or designee will report results monthly to the VP Medical Affairs. VP Quality or designee will report results monthly to the Enterprise Safety and Quality Committee.

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quality of care.
-Assistance with all activities of daily living to include bed mobility, repositioning, and positioning of pressure relieving devices starting on 7/5/23. That was 4 days after her admission.
--Prior to 7/5/23 she had been independent with repositioning.
*Foam boots were not ordered to assist with offloading her heels until 7/10/23.
-That was five days after the wound care team identified DTI's to both of her heels.
-That was ten days after she was admitted to the hospital.

Review of patient 1's 7/1/23 through 8/1/23 nursing care flow sheets revealed:
*She was able to reposition herself until 7/5/23.
*On 7/5/23 she had to be turned and repositioned every two hours.
*Occasionally she had refused personal care but there was no documentation to support she refused to be repositioned.

Review of patient 1's 7/5/23 wound care team documentation revealed:
*"Patient was lying in bed after procedure and states back pain. She was turned with an assist of 2 staff for assessment. Wound to buttocks is slightly open with surrounding non-blanchable tissue. There is another adjacent DTI present to the buttocks. Upon further assessment posteriorly, patient has many DTI's present to her bilateral feet and ankles. The ankle wounds may be consistent with the SCD [sequential compression device for the legs] tubing or garments. All wounds assessed and treatment plan updated. Call was placed to the doctor to update and patient was also updated about new wounds. She [patient] states she was unaware

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any of them were there, just the back wound. A specialty bed will be ordered as well as offloading boots. Please continue to offload."
*The wound care skin assessment documentation identified the following wounds:
-Stage 2 to the coccyx measuring 2.0 centimeters (cm) x (by) 0.5 cm x 0.1cm. Entire wound area surrounded by DTI and no drainage.
-DTI to the right sacral area measuring 1.5 cm x 1 cm.
-DTI to the left heel measuring 4.5 cm x 4.5 cm.
-Right lateral heel DTI measuring 2 cm x 2 cm.
-Right lateral ankle DTI measuring 10.5 cm x 1.5 cm.
-Left anterior ankle DTI measuring 13 cm x 2 cm.
*The coccyx wound had been documented as pre-existing.
-The nursing assessment completed on 7/2/23 had not identified skin problems.
*A low air loss wound care specialty bed had been ordered by the wound care team.
*Wound care instructions for care of the wounds included:
-She was to have been repositioned per the recommendations from the Braden scale assessment form.
-Both of her ankles were to have been offloaded with heel boots and pillows at all times.

Continued review of patient 1's wound care team documentation revealed:
*Her coccyx wound continued to worsen throughout the course of her hospitalization.
*On 7/12/23:
-"Larger sacral wound has opened more and is measuring larger."
-The coccyx wound had serosanguineous (contains both blood and a clear yellow liquid) drainage and measured 7.5 cm x 5.5 cm with a

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wound depth of 0.1 cm.
*On 7/18/23 the coccyx wound had serosanguineous drainage and measured 8.2 cm x 4.2 cm with a wound depth of 0.1 cm.
*On 7/25/23:
-"Wound to sacrum has loose, boggy eschar that was able to be debrided today at the bedside. Strict offloading."
-The wound had serosanguineous drainage and measured 7 cm x 9 cm with a wound depth of 0.1 cm.
*On 8/1/23:
-"Wound to sacrum has significantly deteriorated, 100% slough-filled with loose tissue and now has bone exposed. There is also an area of dusky tissue within the wound bed. Loose slough debrided at bedside. Strict offloading."
-The wound continued to have serosanguineous drainage and measured 10 cm x 10 cm with a wound depth of 1.5 cm.

Review of patient 1's 7/12/23 physician progress note revealed:
*"Overall, patient has not made any improvement since admission, with severe protein calorie malnutrition at baseline, poor functionality, multiple pre-existing pressure sores, prognosis is poor."
*That note had been the first physician progress note to confirm knowledge of her wounds.
-That had been seven days after the wounds first appeared.
*Prior to 7/12/23 the physicians and practitioners had documented her skin to be warm, dry, and intact.

Interview on 12/6/23 at the same time as the EMR review with performance engineer C revealed:

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*She agreed:
-The staff utilized two nurses to complete all the required skin assessments per their policy.
-There was no documentation to support the wounds were identified upon admission and were pre-existing prior to her admission to the hospital.
-The documentation supported that the patient acquired all the wounds during her hospitalization.
-The documentation supported the hospital staff had been reactive versus proactive in preventing the patient from acquiring wounds while under their care.
*She stated:
-"The staff have four hours to complete their skin assessments upon admission to the facility and when admitted to each different unit and to determine if they had pre-existing wounds."
-"All the documentation supports they used two people for all those assessments to."

2. Observation on 11/29/23 at 9:00 a.m. with RN E with patient 9 revealed:
*The patient:
-Was lying on a low air loss bed and was positioned on her back.
-Was alert, oriented, and capable of making her needs known.
-Confirmed the nurse was going to assess the wound on her heel along with her other wounds.
-Was obese and required assistance with shifting from side to side.
-Had a pillow positioned under her left leg and foot with the heel resting on it.
*RN E:
-Had prepared to assess and re-dress the patient's wounds.
-Assisted the patient to roll-over on her left side.
-Removed a dressing on the patient's coccyx,

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right heel, and right posterior foot.
*The heel was dark maroon in color and spanned the entire width of the patient's heel.
*The patient stated: "That is new, I didn't come in with that one."
*She had a smaller wound to her right lateral foot that was covered with a tan colored scab.

Review of the patient 9's EMR with performance engineer B revealed:
*She was admitted on 10/27/23 from a critical access hospital for further work-up for rectal bleeding.
*Her diagnoses included: gastrointestinal hemorrhage, end-stage renal disease and was on hemodialysis, morbid obesity, diabetic foot infection, high potassium level, uncontrolled type 2 diabetes, left below the knee amputee, and anemia with required blood transfusions.
*On 11/26/23:
-The wound care team received a new consult order from nursing to evaluate her right heel.
-"WCT [wound care team] noted deep tissue injury to heel and additional DTI's to lateral foot and right 2nd and 3rd distal toes."
-She had been wearing an offloading boot and after the wounds were assessed and treated the boot was reapplied.
-The right heel wound was intact and measured 6 cm x 5 cm in diameter.
-The right lateral foot was dry, intact and measured 2 cm x 1 cm in diameter.
-The WCT had documented that all of the new wounds that were assessed had been pre-existing.
*There was no documentation to support the right heel and right lateral foot had been identified prior to her admission date of 10/27/23.
*Wound care instructions for nursing to follow for

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the right heel and right lateral foot were entered into the computer system on 11/26/23.
-That was approximately one month from the time of her admission date.
*Performance engineer B confirmed the above EMR review.

3. Observation on 11/29/23 at 9:35 a.m. of RN E with patient 10 revealed:
*The patient was lying in bed on her back.
*The unidentified physician was:
-At her bedside talking with her and completing her assessment.
-Waiting for assistance to look at a new acquired wound to her coccyx area.
*The RN:
-Gathered the supplies to assess and dress the patient's new wound.
-Removed the old dressing to expose the wound on her coccyx area.
-Confirmed it was a new wound and she had received notification to assess it and provide orders the treatment.
*The wound:
-Was open, moist, and had minimal drainage to the old dressing.
-Measured 1.5 cm x 1.0 cm.

Review of patient 10's EMR with performance engineer C revealed:
*She was admitted on 11/12/23 through the ED after the removal of her gallbladder.
*The nursing staff completed a skin assessment within the required four hours with two nurses.
*There was no documentation to support that they identified a wound to her coccyx area upon admission.
*On 11/27/23 the nursing staff identified the open are to her coccyx and notified the WCT to

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complete an assessment.
-That was fifteen days after her admission to the hospital.

Interview on 11/29/23 at 10:00 a.m. with RN E regarding the above observations with patients 9 and 10 revealed:
*She confirmed:
-Their evaluations came from nursing and they had 48 hours to assess the patient.
-The nursing staff had the capability to implement pressure relieving measures and devices prior to the WCT's assessment.
-The nursing staff were required to complete a skin assessment on all patients within four hours of admitting.
-There should have always been two nurses who assessed the patient's skin to support the current skin condition.
-Patient 9 and 10 received the newly assessed wounds while receiving care during their hospitalization.
*She offered no comment on whether the staff had been reactive or proactive when identifying and/or preventing wounds from occurring while patients were hospitalized..

Review of the provider's April 2023 Skin Assessment: Prevention, Treatment, Reassessment and Documentation policy revealed:
*Policy Statement:
-"Provide a consistent approach to skin care management for patients with impaired or the potential for impaired skin integrity."
-"Identify patients at risk for developing skin breakdown and/or pressure ulcers and institute a plan of care that includes preventative measures, ongoing monitoring and assessment of wounds,

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treatment and documentation."
*General Prevention Measures for all patients, unless medically contraindicated:
-"Turn immobile patients at least every 2 hours. Specialty beds are not a replacement for tuning."
-"Prevention activities will be continued to prevent additional skin breakdown even if a patient has an identified pressure ulcer."
-Nursing staff and nursing assistants would remain integral parts of the treatment phase.

B. Based on record review, interview, and policy review, the provider failed to ensure one of one sampled patient (17) had been provided treatment for wounds that had been identified during his hospitalization. Findings include:

1. Review of patient 17's electronic medical record (EMR) revealed he:
*Had been admitted on 9/29/23 and discharged on 10/2/23.
*Had been diagnosed with confusion, altered mental status, and possible drug intoxication.
*Had been incarcerated in the county jail and had a police officer present during his hospitalization.
*Required four point restraints on 9/29/23 at 10:10 p.m. along with his wrist and ankle cuffs.
*Had been transferred to the intensive care unit on 9/30/23 at 4:30 a.m. for further sedation with the use of a Precedex drip (medication used to keep you asleep during surgery or other medical procedures).
*Had been identified on 9/30/23 at 8:00 a.m. having abrasions to his right and left hands.
-No documentation of any treatment had been implemented upon the discovery of the abrasions.
*Had been identified on 10/1/23 at 8:00 a.m. with bruising, weeping abrasion marks from the use of the hand cuffs.

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-No documentation of any treatment had been implemented upon discovery of the new skin condition.

Interview on 12/7/23 at 8:15 a.m. with performance engineer C regarding the treatment for the identified wounds on patient 17 revealed:
*She had felt that a nurse's judgement would have determined if a dressing or treatment had been required.

Review of the provider's December 2022 Wound Care Protocol policy revealed:
*"Patients requiring wound care should have access to the correct treatment and dressings in a timely, efficient manner with minimal discomfort."

Review of the provider's April 2023 Skin Assessment: Prevention, Treatment, Reassessment, and Documentation policy revealed:
*"Simple wounds- any incision or wound that was a break in skin integrity, but now is closed and progressing without complication through the normal stages of healing."
*"Intervention: Treatment Measures:
-"For ulcerations or other actual breaks in skin integrity including those that are traumatic or therapy-induced, a separate occurrence (referred to as an line, drain, or airway (LDA)) will be made for each wound."
*"Documentation for all wounds will include at a minimum:
-"Detailed location description."
-"Location."
-"Type of wound."
-"Wound color and characteristics prior to treatment/dressing change note."

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-"Surrounding tissue color and characteristic."
-"Wound drainage amount and description."
-"Dressing description."

Review of the provider's December 2022 Restraint and Seclusion Use policy revealed:
*"Restrained patients will be assessed based upon the patient's status."
*"Care will also be provided to all patients in physical restraints and documented by the registered nurses, licensed practical nurses, patient care technicians, or behavioral health staff who have demonstrated competence. The patient's plan of care will be modified to include the following:"
"-Check for signs of any injury associated with the application of a restraint."

Review of the provider's September 2023 Wound Care Registered Nurse job description revealed:
*"You will be an active contributor to the prevention or resolution of illness, disability or injury, alleviation of suffering, and advocacy in the care of individuals in conjunction with interdisciplinary teams and healthcare providers, family members, and support systems."
*"You will exercise independent judgement in utilizing the nursing process to assess, diagnose, identify outcomes, plan, implement, and evaluate direct patient care in accordance with ANA (American Nurses Association) Standard of Professional Nursing Practice, institutional polices and procedures, application laws, and regulations."
*"Essential functions:"
-"Health Teaching and Health Promotion-employs strategies to promote health and a safe environment."
-"Practice in an environmentally safe and healthy

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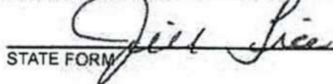
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A complaint health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, Critical Access Hospital, and Rural Emergency Hospital Facilities, was conducted from 11/28/23 through 11/29/23 and 12/4/23 through 12/8/23. Areas surveyed included nursing services for facility acquired pressure ulcers and wound care. Monument Health Rapid City Hospital was found not in compliance with the following requirement: S145.	S 000		
S 145	44:75:02:10 Infection Prevention and Control Program Each facility shall have an active, facility-wide program for the surveillance, prevention, and control of healthcare-associated infections and other infectious disease. The program must demonstrate adherence to nationally recognized infection prevention and control guidelines. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain infection control practices and techniques during two of two sampled patient's (9 and 10) wound care by one of one registered nurse (RN) E. Findings include: 1. Observation on 11/29/23 at 9:00 a.m. of RN E with patient 9 revealed: *The RN: -Gathered the necessary supplies and equipment to perform wound care for the patient. -Entered the patient's room and placed all the supplies on a clean barrier. *The RN had sanitized her hands before entering	S 145	Manager of Wound Care, Wound Care Clinical Quality Coordinator, and Infection Control Director developed education regarding wound care infection control to emphasize hand hygiene, general glove use to include changing gloves between appropriate tasks, cleaning and use of multi-patient care items, and personal protective equipment. Education will be completed by all Rapid City Hospital Wound Care Nurses by January 3, 2024. Wound Care Nurses on leave will be required to complete education prior to the first worked shift. Department Manager or designee will monitor education completion and report to the Vice President of Quality, Safety, Risk Management and the Vice President of Operations. Director of Infection Prevention and Control and Director of Plant Operations discussed ensuring hand sanitizer dispensers are installed in all inpatient rooms. A plan was developed to install hand sanitizer dispensers in rooms that currently are without. Plant Operations completed installation on December 22, 2023, this was verified by Director Infection Prevention and Control.	01/03/2024

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



TITLE: V.P. Quality, Safety, Risk Management

(X6) DATE: 12/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10558 S	A. BUILDING: ____ B. WING ____	C 12/08/2023

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S 145	Continued From page 1 the room and put on a clean pair of gloves. *With those gloves on she: -Took her cell phone out of her pocket and placed it on the clean barrier with the dressing supplies. -Removed the patient's blanket and pillows before assisting the patient to turn on her left side. -Removed the dressing that contained serosanginous drainage from the patient's left buttocks. -Opened the bottle of saline and a package containing a 4 x 4 gauze. -Moistened the gauze with the saline and then cleansed the wound. *The patient had two small open areas along an incision site that was created from a wound that required surgical repair. *With those same gloved hands she: -Took the patient's phone per the patient's request and took a picture of the wound. -Took her work cell phone and obtained measurements and pictures of the wounds. -Opened another package, removed a protective dressing, and applied it to the wounds. *She removed those gloves and without washing her hands put on another pair of clean gloves. *With those gloves she: -Removed a dressing from the patient's right heel and lateral side of the foot and toes. -Opened a 4 x 4 package containing gauze and moistened it with the saline. -Cleansed the heel, the wound on the lateral side of the foot, and three toes that each had a small scab. -Took her work cell phone and measured and photographed the wounds. -Opened two more packages and removed the protective dressings. -Applied the dressings to the wounds. *She:	S 145	Monitoring: Department Manager or designee will visualize 10 inpatient wound care team treatments monthly to ensure appropriate hand hygiene and glove use, cleaning and use of multi-patient care items, and proper application of personal protective equipment. Monitoring will continue until 100% compliance is sustained for 3 consecutive months. Results will be reported monthly to the Vice President of Quality, Safety, Risk Management and the Vice President of Operations.	

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S 145	Continued From page 2	S 145		

-Removed her gloves and sanitized her hands with the sanitizer that was located outside of the room. There was no sanitizer to use inside of the patient room. She could have washed her hands at the sink in the patient's room.
-Took a germicidal wipe and cleaned her phone with it.
-Placed the clean phone on the countertop by the sink outside of the patient's room that was used by staff.
-Washed her hands at the sink and put the phone back inside of her pocket.

Observation on 11/29/23 at 9:35 a.m. of RN E with patient 10 revealed:
*The RN:
-Gathered the necessary supplies and equipment to perform wound care for the patient.
-Entered the patient's room and placed all the supplies on a clean barrier.
*The RN sanitized her hands prior to entering the room and put on a clean pair of gloves.
*With those clean gloves the RN:
-Took her work cell phone out of her pocket and placed it on the barrier with the dressing supplies.
-Removed the patient's blanket and pillows before assisting the patient to turn on her right side.
- Removed the old dressing from the patient's coccyx.
-Opened the bottle of saline and a package containing 4 x 4 gauze.
-Moistened the gauze with the saline and cleaned the wound.
*The patient had an open wound at the bottom of her coccyx.
*With those same gloves she:
-Took her work cell phone and obtained measurements and pictures of the wounds.
-Opened a small tube of protective cream and

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S 145	Continued From page 3 applied it around the outer edges of the wound -Opened another package, removed a protective dressing, and applied it to her wounds. *She: -Removed her gloves and sanitized her hands with the sanitizer that was located outside of the patient's room. She could have washed her hands at the sink in the patient's room. -Took a germicidal wipe and cleaned the phone. -Placed the clean phone on the countertop by a sink outside of the patient's room that was used by staff. -Washed her hands at the sink and put the phone back inside of her pocket. Interview on 11/29/23 at 10:00 a.m. with RN E regarding the observations above with patients 9 and 10 revealed: *She: -Confirmed that had been her usual process for assessing and changing patient wound dressings. -Had not recognized the outside of packages, bottles, her cell phone, and medication tubes as unclean. -She should have removed her gloves between each task, washed or sanitized her hands, and applied new gloves. *She stated: -"I usually try to be as careful as possible." -"I didn't even recognize that I didn't change my gloves often enough or clean my hands and I should have." *She agreed the process: -Created the potential for the transmission of bacteria to enter all those wounds. -Created the potential for infection to occur in the wounds and impact the healing process. Interview on 12/8/23 at 8:05 a.m. with infection preventionist O regarding the above observations	S 145		

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S 145	Continued From page 4 and interview revealed: *He would have expected: -Hands to have been sanitized between glove changes. -Gloves should have been removed between each task, sanitized her hands, and then applied a new pair of clean gloves. -Hand hygiene should have occurred between the care and treatment of each patient's wound. *He confirmed the processes described above would have created the potential for the transmission of bacteria into those wounds and might have possibly created an infection. -That process had the potential to affect the healing process of those wounds. *He stated: -"I know there are only sanitizers outside of the rooms but I've gotten pushback on that." -"That there would be to much sanitizer in the area then" -"They should be sanitizing on their way in and before leaving the room." -"They don't have that capability with our current set-up." Review of the provider's December 2022 Hand Hygiene policy revealed: *"Handwashing is the most effective means of preventing transmission of infections." *"Handwashing or cleansing with alcohol-based hand rub foam or gel must be done before entering and upon leaving a patient room and prior to beginning and after completing any treatments or therapies with the patient or within the patient's environment." *"Alcohol-based hand rub products can be used when hands are not visibly soiled."	S 145		

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

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	430077	A. BUILDING ______ B. WING ______	R-C 02/27/2024

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A 000	INITIAL COMMENTS An onsite revisit survey was conducted on 2/21/24 through 2/22/24 and 2/27/24 for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals for all previous deficiencies cited on 12/8/23. All deficiencies have been corrected and no new non-compliance was found. Monument Health was found in compliance with all regulations surveyed.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/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.