STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10563 S	A. BUILDING: _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALT	1325 S CLIFF AVENUE POST OFFICE BOX 5045 SIOUX FALLS, SD 57117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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, and Critical Access Hospital Facilities, was conducted from 11/25/24 through 11/26/24. Areas surveyed included Nursing Services. Avera McKennan Hospital & University Health Center was found not in compliance with the following requirement: S252.	S 000	The following plan of correction addresses the issues with: 1. Neurological checks completed after a fall on 9/16/24 and 9/18/24 for two of five sampled patients (1, 2). 2. Pain assessment completed on one of five sampled patients (1) after an unwitnessed fall. 3. Physician involvement and notification of a fall on 9/18/24 for one of five sampled patients (2). 4. Documentation of a wound assessment completed for one of five sampled patients (2) who sustained abrasions to the mid and upper back from a fall on 9/18/24.	
S 252	44:75:06:03 Nursing Policies and Procedures The facility shall establish and maintain policies and procedures that assist the nursing staff with meeting its administrative and technical responsibilities in providing care to patients including: (1) The noting of diagnostic andtherapeutic orders; (2) Assigning the nursing care of patients; (3) Administration and control of medications; (4) Charting by nursing personnel; (5) Infection control; (6) Patient safety; (7) Delineation of orders from nonphysician practitioners; and (8) Discharge planning. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure the fall risk policy had been followed as evidenced by no: *Neurological checks completed after a fall on 9/16/24 and 9/18/24 for two of five sampled patients (1, 2). *Pain assessment completed on one of five sampled patients (1) after an unwitnessed fall.	S 252	The BHS Vice President, Inpatient Director, Clinical Nurse Educators, Risk Manager, Accreditation Manager, and Inpatient Adult Managers participated in a meeting to discuss nursing post fall assessment and documentation on the Adult B and C units at Avera Behavioral Health Hospital. Current fall policy, staff education, and training were reviewed. Gaps in knowledge were identified. A remediation plan was developed and includes policy update, fall intervention review, mandatory nursing education, and leader fall audits. Avera Behavioral Health Hospital leadership along with education, risk management, and accreditation to identify opportunities for improvement related to our Fall Risk, Adult policy, post fall assessment and documentation. Previously the Fall Risk, Adult policy did not specifically state what assess and document in the event of a fall during a hospitalization. On 11/27/24 the Fall Risk, Adult policy, fall during hospitalization was updated to require assess the patient and document of pain. Fall during hospitalization: 1. RN will assess the patient and document findings: - any sign of injury, such as broken bones, skin tear, etc; - neuro status, if patient may have hit his/her head or it is unknown if patient hit his/her head, repeat neuro checks every 4-hours for 24 hours, or as	11/26/24 11/27/24

			directed by provider; - obtain VS - assess pain 2. provide urgent care appropriate to the injury 3. notify the provider 4. document the Post-Fall assessment and Interventions prior to completing the QM occurrence report 5. document an occurrence report in QM 6. after a patient falls, they must remain a "high fall risk" through the remainder of their inpatient stay.	
			As a second layer of assurance Clinical Nurse Educators and Accreditation Manager Secondary met with Manager of IT Patient Care Services to require the completion of specific fields in Expanse Post Fall intervention. Fields able to be required are fall observed or unwitnessed and notifying the provider.	12/11/24
			Education Provided:	
			High alert email was sent to all adult nurses stating all nurses from Adult A, B, and C are required to attend mandatory education on falls. There are 3 sessions: Dec 9 0730-0830, Dec 9 1730-1830, and Dec 10 1330-1430. All nurses have been registered to attend a class and marked it on their schedule.	11/27/24
			Mandatory nurse education was held in person for all adult inpatient nurses with badge swipe sign in. This education included how to add the post fall standard of care including the post fall intervention and the neuro check intervention. Education was completed on witnessed and unwitnessed falls, pain assessment, provider notification, neuro checks and wound. It was discovered that many nurses were adding the one intervention for the post fall assessment. There is an intervention set that includes the neuro checks. Nurses were educated to add the set and use the post fall huddle checklist to ensure assessment items are not missed.	12/9/24 & 12/10/24
			Badge buddies were created and given to all nurses as a quick guide for post fall documentation.	12/9/24 & 12/10/24
			Updated Fall Huddle checklist to include pain assessment, reiterate fall level movement. This is required to be completed by nurses and given to leadership to ensure all documentation is completed.	12/4/24
			Fall Education added to New Nurse Orientation along with handing out badge buddies and the Fall Huddle Checklist will be in the new nurse folders and given at orientation.	12/4/24
			An audit spreadsheet was created for Adult Unit	11/26/24

			leaders to audit all falls on the adult units. Audits will specifically look at post fall documentation: did patient hit head, was provider notified, was pain intervention documented after fall, post fall neuro checks 24 hours (if hit head or unwitnessed), if new wound obtained, assigned nurse, all components of documented corrected, date and level of remediation if applicable. Audits began. Specifically look at documentation of: if the falls are observed or unwitnessed, if the patient hit their head provider notification, pain assessment, neuro assessment, nurse involved, if wound was assessed, and if documentation was correct. If there are gaps, remediation will be documented with the date provided. Leaders will address continued noncompliance with the Avera corrective action process. Once 100% compliance is achieved verification of sustainability will be performed by the Behavioral Health Quality Specialist by conducting monthly audits x 6 months. Adult Unit leadership will be notified of documentation issues and trends. Data collected from Adult Unit fall audits will be reported out to the Fall Committee.	11/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President and CEO | (X6) DATE: 12/12/2024

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S 252	Continued From page 1 *Physician involvement and notification of a fall on 9/18/24 for one of five sampled patients (2). *Documentation of a wound assessment completed for one of five sampled patients (2) who sustained abrasions to the mid and upper back from a fall on 9/18/24. Findings include: 1. Review of patient 1's medical record revealed: *She was admitted on 9/15/24 and discharged on 9/22/24. *Her fall risk assessment had been completed on 9/15/24 at 3:56 p.m. *Her fall risk score was a 7, which indicated she had no fall risk. *She was placed on universal falls precautions (UFPs) per the facility's fall program that included: -"Call light/belongings in reach when appropriate. -Bed in low position and locked as appropriate. -Wheelchairs and chairs locked as appropriate. -Side rails up X2 [two rails] for medical beds. -Use of footwear. -Ensure adequate lighting. -Clutter free and spill free environment. -Educate patient on level of risk. -Educate on how to call staff for assistance." *UFPs documented were adequate lighting. *she had an unwitnessed fall on 9/16/24 at 12:36 a.m. *It was unknown if she hit her head. *There was no documentation that indicated her pain was assessed at the time of the unwitnessed fall. -Her pain was assessed on 9/15/24 at 11:25 p.m. and again on 9/16/24 at 9:40 a.m. *There was no documentation that indicated initial and ongoing neurological checks were completed.	S 252		

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S 252	Continued From page 2 Interview on 11/25/24 at 2:35 p.m. with clinical educator F confirmed: *Neurological checks should have been assessed and documented for an unwitnessed fall per the provider's policy. *A pain assessment should have been documented at the time of the unwitnessed fall. *She stated, "If it's not documented, it hasn't been completed." 2. Review of patient 2's medical record revealed: *He was admitted on 9/5/24 and discharged on 9/19/24. *His fall risk assessment had been completed on 9/5/24 at 3:57 p.m. *His fall risk score was a 3, which indicated he had no fall risk. *UFP's documented were belongings within reach. *He had an unwitnessed fall on 9/18/24 at 3:38 a.m. *It was unknown if he hit his head. *There was no documentation that indicated initial and ongoing neurological checks had been completed. *No documentation of notification to physician had been completed. *Registered nurse D had documented "abrasions to mid and upper back; generalized pain 4/10 [4 on a zero to ten scale]." *A fall risk assessment completed on 9/18/24 at 3:36 a.m. indicated he had a high fall risk. *Another fall risk assessment completed on 9/18/24 at 9:00 a.m. indicated he had no falls and was not a high fall risk. *No fall assessment was completed on the day of his discharge. *His documented pain score from 9/18/24 through 9/19/24 ranged from 8 to 10 and was located in his neck and shoulder.	S 252		

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S 252	Continued From page 3 *No assessment of abrasions had been documented from the time of his fall to his discharge. *Interdisciplinary rounds with nursing, pharmacy, psychiatrist, resident, and social services had been completed on 9/18/24 at 10:17 a.m. with no documentation of the patient's unwitnessed fall during the night. *Psychiatrist A progress note on 9/18/24 at 5:30 p.m. indicated: -Patient 2 "Fell last night-reports he tripped on a slippery spot on his floor, was not wearing his anti-skid socks. He only slept about 2.5 hours as a result. Notes an increase in pain overall, especially running down his back." *No additional physician orders had been written related to his fall. Interview on 11/25/24 at 4:00 p.m. with clinical educator F revealed she: *Agreed with the above findings. *Would have expected physician notification of falls to be documented in a patient's electronic medical record (EMR). *Would have expected neurological signs to have been assessed and documented in the patient's EMR per their policy. *Agreed the nurse should have added a documented wound assessment for patient 1's abrasions. *Confirmed patient 2 should have remained a high fall risk until discharge. 3. Interview on 11/25/24 at 10:17 a.m. with psychiatrist A regarding patient 2 revealed: *She stated, "It depends on the situation if the nurse would contact the physician." *During the night, staff would have called the resident (physician in training), but she was unsure if the staff had called after patient 2's fall.	S 252		

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S 252	Continued From page 4 *She confirmed patient 2 had hit his head. *She had not been aware if nurses had completed neurological checks after patient 2's fall. *There had been no concerns of any acute change in patient 2's status. *She had been aware of patient 2's 8 to 10 pain ratings. *Patient 2's pain level had not changed from his baseline. *She stated, "I don't think the patient should have gotten a CT scan-there was no deviation from his baseline." *She confirmed patient 2 on discharge complained of neck pain which was not a new complaint. 4. Interview on 11/25/24 at 1:37 p.m. with registered nurse (RN) B revealed: *A patient's fall risk assessment was to be completed on admission. *If the patient's fall risk was high staff would have: -Placed a sign on the door. -Placed a wristband on the patient that indicated the patient had a fall risk. -Put yellow socks on the patient. *If a patient had an unwitnessed fall, she confirmed staff would have: -Assessed the patient. -Checked the patient's vital signs. -Performed neurological checks. -Alerted the doctor. -Assessed the patient's pain. -Assessed for any skin issues that had occurred from a fall and document twice a day. -Documented the incident in the patient's EMR. 5. Interview on 11/26/24 at 8:15 a.m. with RN C revealed: *A fall risk assessment was to be completed	S 252		

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S 252	Continued From page 5 every shift. *She confirmed if patients fall, the RN should have: -Obtained a set of vital signs. -Communicated to the physician for both witnessed and unwitnessed falls. -Performed neurological checks if patients hit their head or if unknown. -Asked the patient about their pain. *Documentation should have been completed in the EMR. 6. Interview on 11/26/24 at 8:29 a.m. with RN D revealed she: *Regarding patient 2's fall above, she heard a loud noise when she was at the nurse's station and found patient 2 sitting on the floor. *Thought he had tripped on the stool in his room. *Checked his skin and had not seen any abrasions or open areas. *Had not called the physician or resident after patient 2's fall. *Stated, "Neurologically he was intact, we don't call the providers if neuros are fine." *Documented the patient's initial neuro signs in the EMR. *Hadn't performed another neurological check on patient 2 because the first assessment was normal. *Would not have put signs on the door if patients are a high fall risk. 7. Interview on 11/26/24 at 8:56 a.m. with director of inpatient services and residential treatment facilities E revealed she: *Would have expected neurological checks to have been completed per their fall policy. *Stated, "We are finding documenting neurological checks as an opportunity for improvement."	S 252		

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S 252	Continued From page 6 *Would have expected the physician to have been notified of any patient falls. *Would have expected a patient's pain to have been assessed and documented after a fall. *Would have expected a wound assessment to have been completed and documented for patient 2's abrasions. 8. Review of the provider's undated Fall Huddle Checklist revealed: *"1. Assess the patient for any signs of injury and provide care as appropriate -Vital signs and document -Neuro assessment and document (Q4H x 24 hours if patient hit head, or if unknown) -Skin assessment (if new) and document *2. Document findings in real time *3. Communication -Notify provider of event/assessment findings -Update family -Update all staff with a quick debrief of situation -Notify leader on call *4. Report incident *5. Update Fall interventions as instructed per care plan -Bed Alarm/Chair alarm -Fall Mat -Patient will be HIGH RISK now regardless of score." 9. Review of the provider's November 2023 Fall Risk, Adult policy revealed: *"A patient fall is defined as a sudden unintentional descent with or without injury to the patient that results in the patient coming to rest on the floor, or on against some other surface (e.g., a counter), or another person, or an object (e.g., a trash can). *If a patient falls during hospitalization, he/she is considered a higher fall risk for the remainder of	S 252		

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S 252	Continued From page 7 his/her hospitalization." *A fall risk assessment is completed -1. Upon admission or before transfer to another unit, as patient condition allows -2. By the receiving nurse after any transfer to another location/unit -3. Twice a day for medical/surgical patients, and once a day for behavioral health patients -4. After a fall event -5. With a change in status -6. Prior to discharge *If a patient falls during hospitalization -1. Assess the patient for any sign of injury, such as broken bones, skin tear, etc.; assess neuro status, if patient may have hit his/her head or it is unknown if patient hit his/her head, repeat neuro checks every 4-hours for 24 hours, or as directed by provider); obtain VS -2. Provide urgent care appropriate to the injury -3. Notify the provider -4. Document the Post-Fall assessment and interventions prior to completing the QM occurrence report -5. Document an occurrence report in QM -6. After a patient falls, they must remain a "high fall risk" through the remainder of their inpatient stay." 10. Review of the provider's February 2024 Patient Care Guideline: Pain policy revealed: *"Frequency of assessment is determined by the route of analgesic administration, patient's response to analgesia, and the patient's clinical condition. *The patient's pain level, whether or not pain is controlled, and current pain interventions will be evaluated on an ongoing basis."	S 252		