STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80078	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB & CRITICAL CARE HOSPITAL OF THE BLACK	2115 PROMISE ROAD RAPID CITY, SD 57701

(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 An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 7/09/24 through 7/11/24. Rehab & Critical Care Hospital of the Black Hills was found not in compliance with the following requirements: S146, S221, S231, S233, S253, S261, and S270.	S 000		
S 146	44:75:02:10(1-5) Infection Prevention and Control Program Each facility shall, based on recommendations from the facility's medical and nursing leadership, appoint an infection prevention and control director who is qualified through education, training, experience, or certification in infection prevention and control, to be responsible for the infection prevention and control program including: (1) Developing and implementing policies and procedures for facility-wide infection surveillance, prevention, and control that reflect the scope and complexity of services furnished by the facility and that maintain a clean and sanitary environment; (2) Documenting infection prevention, control, and surveillance activities; (3) Communicating and collaborating with the quality assessment and performance program required by § 44:75:04:14 and the antibiotic stewardship program required by § 44:75:02:10.01 on infection prevention and control issues; (4) Ensuring competency-based training and education is provided to the facility's healthcare personnel; and (5) Auditing adherence to the facility's infection	S 146	All patients, staff and visitors have the potential to be affected by this deficiency. No adverse effects have been noted. Clinical staff education started on 7/11/2024 with the Therapy staff. Nursing staff educated at staff meeting held on 7/24/2024 and 7/25/2024. Nursing supervisor will educate staff not in attendance prior to next shift. Education from Director of Quality and Professional Development Coordinator included hand hygiene, PPE utilization, handling of blood glucose testing procedure, clean to dirty when providing care, and cleaning of medical equipment. The following policy was reviewed and signed by staff - Infection Prevention - Hand Hygiene. A new process for bedside blood glucose testing was implemented on 7/30/2024 with an emphasis on keeping supplies free from contamination. All nursing staff have been educated to follow infection control policies and practice at the staff meetings held on 7/24/2024 and 7/25/2024 with nursing supervisors completing education prior to next shift for those not in attendance to ensure compliance and patient, staff and visitor safety.	8/20/2024

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S 146	Continued From page 1 prevention and control policies. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *The handling of blood glucose supplies by one of one certified nursing assistant (CNA) (G). *Proper personal protective equipment (PPE) used by one of one nurse supervisor (H). *Staff intervention and education for one of one unidentified visitor regarding proper hand hygiene (HH) and PPE use. *The completion of oral care by one of one licensed practical nurse (LPN) (U) for one of one sampled patient (8) who had a wound to her left upper lip and open wounds inside of her mouth from being wired shut. *A dressing changed by one of one registered nurse (RN) (H) to a peripherally inserted central catheter (PICC) for one of one sampled patient (5). Findings include: 1. Observation and interview on 7/9/24 at 11:30 a.m. with CNA G preparing to take patient 12's blood sugar reading revealed she: *Gathered a glucometer, cotton ball, alcohol prep pad, blood test strip, a lancet, and placed those supplies inside of her smock pocket. *Performed HH and put on gloves before entering the patient's room. *Removed the glucometer from her pocket and inserted the test strip into the glucometer. *Wiped the patient's fingertip with the alcohol pad before pricking it with the lancet. *Removed blood from the patient's fingertip with the cotton ball.	S 146	The Infection Preventionist (IP) or designee will audit 50 hand hygiene, 50 PPE utilization, 50 cleaning of medical equipment and keeping supplies clean and 50 care events for first 3 weeks,then 40 audits every other week for 3 times to ensure 100% compliance and finally 30 audits per month for 3 months to ensure sustained 100% compliance. The IP or designee will report monthly to the QAPI committee for follow up. The QAPI committee will review the audit results and if necesssary make any recommendations for improvement.	

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S 146	Continued From page 2 *Completed the blood sugar testing process before discarding her used supplies, disinfecting the glucometer, removing her gloves, and performing HH. *CNA G confirmed she failed to handle the blood sugar testing supplies referred to above in a sanitary manner after she placed them inside of her smock pocket. 2. Observation and interview on 7/9/24 at 12:30 p.m. with nurse supervisor H inside of patient 9's room revealed: *There was infection control signage posted outside of the patient's room regarding the need for hand hygiene, PPE (gown and gloves), and "bleach precautions." *Nurse supervisor H sat on the edge of the patient's unmade bed. -The back of her gown was opened so her scrub pants were in direct contact with the patient's sheets. *She agreed she should not have been sitting on the patient's bed. -Her gown failed to protect the back of her scrub pants having direct contact with the patient's bedding. 3. Observation on 7/9/24 at 12:40 p.m. of patient 8's room revealed: *Infection control signage posted outside of the patient's room regarding hand hygiene, PPE use, and bleach precautions. *An unidentified woman in the patient's room was not wearing PPE. -She exited the room without performing HH, approached the nurses' station and asked for a pen. *RN L handed the woman a pen and stated "You can just keep it." *Without performing HH or putting on PPE the	S 146		

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S 146	Continued From page 3 woman re-entered the patient's room. Interview on 7/9/24 at 1:00 p.m. with RN M regarding the observation referred to above revealed she: *Was the RN responsible for patient 8's care. *Was not aware of the unidentified woman referred to above otherwise she would have educated her regarding HH and worn PPE expectations with that patient. Interview on 7/9/24 at 1:05 p.m. with nursing assistant (NA) I regarding the unidentified woman in patient 8's room revealed: *The woman was the patient's friend who had "been here all day." -She fed the patient, assisted with her care, and sometimes stayed overnight in the patient's room. *She stated "I don't know the requirement" regarding the expectation of the friend to have performed HH and worn PPE when she entered and exited the patient's room and when she assisted the patient with personal cares. 4. Observation on 7/10/24 at 9:20 a.m. with LPN U while she assisted patient 8 with revealed: *The patient was on contact precautions. *The nurse entered the room with a gown and gloves on. *She assisted the staff with positioning the patient in her wheelchair (w/c). *She retrieved the w/c pedals and armrests from the bathroom and put them on the patient's w/c. -Both the pedals and armrests had been laying on the bathroom floor. *The patient's jaw had been wired shut and required the nurses' assistance with her drinking, eating, and oral cares. -She had a large, hard, and black colored wound	S 146		

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S 146	Continued From page 4	S 146		

on the left side of her upper lip.
*The nurse gathered the patient's oral care supplies.
-She gathered those supplies with the same gloved hands she had used to assist the patient with positioning in the w/c, putting pedals, and armrests on the patient's w/c.
*With those same gloved hands she:
-Retrieved a 60 cubic centimeter (CC) syringe from the patient's bedside table.
--The package that the syringe was in had been laying directly on the patient's bedside table.
*She:
-Took the younker (device to suction the patient's mouth) out of its package that was hanging on the suction valve on the wall.
-Turned the water faucet on to get the patient a drink of water before cleaning her mouth. She had not used a barrier to protect the gloves from touching the dirty handles.
-Opened the container with the mouthwash in it and pulled some of the liquid up with the syringe.
-Used the syringe to put the mouthwash in the patient's mouth so she could swish it around.
-Touched the valve for the suction and turned it on so she could suction the liquid out of her mouth.
-Took a washcloth and wiped the patient's mouth dry.
*After she completed the patient's oral care she took her gown and gloves off.
*Prior to leaving the room she turned the water faucet on and washed her hands at the sink.
*She then touched the dirty faucet handles with her clean hands to turn off the water and exited the room.

Interview on 7/10/24 immediately following the above observation with LPN U regarding her process for assisting the patient with oral care

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S 146	Continued From page 5 revealed: *That had been her normal process for assisting the patient with oral care. *She agreed that the processes had not been sanitary and created the potential for cross contamination of bacteria to the patient. -That could have created the potential for infection to occur on the patient's wound and in her mouth. *She was not aware that the faucet handles had not been a clean surface and she should not have touched them with her clean hands.. 5. Observation on 7/10/24 at 3:48 p.m. with RN/nurse supervisor H during a dressing change on patient 5's PICC revealed she: *Gathered the necessary supplies to complete that dressing change and laid them directly on the patient's bedside table. *She laid a clean disposable pad on the table, picked the packages back up, and laid them on top of that pad. *Sanitized her hands and put on a clean pair of gloves. *With those gloves she: -Assisted the patient in repositioning in bed on her back and placed a pillow underneath her right arm. -Pushed the patient's shirt up her arm so she could have complete access to her PICC line. -Put a clean mask on herself and one on the patient. *After touching all those unclean surfaces she: -Used her fingers to stabilize the catheter line and removed the old dressing from the PICC line. -She held the catheter line in close to the insertion site of the PICC line. *She removed her gloves, sanitized her hands, and put on a pair of sterile gloves for the dressing change.	S 146		

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S 146	Continued From page 6 *Completed the rest of the dressing change without further observed concerns.. Interview on 7/10/24 at the time of the above observation with RN H revealed: *That had been her usual process for completing a PICC line dressing change. *She agreed: -That process had not been sanitary and created the potential for cross-contamination of bacteria to the patient's open PICC line site. -That was considered an open wound and her observed process could have created the potential for infection to occur at that site. Interview on 7/11/24 at 8:25 a.m. with chief nursing officer (CNO) B, RN C, and RN R regarding the above observations revealed: *They had not been aware the staff were not completing those tasks in a sanitary manner. *They agreed those processes created the potential for cross-contamination of bacteria to occur and placed the patients at risk of acquiring an infection. Review of the provider's September 2023 Hand Hygiene policy revealed: *"Staffing shall follow CDC guidelines for hand washing for at least fifteen (15) seconds in the following situations: -After handling items potentially contaminated with blood, body fluids, or other potentially infectious material." *"If hands are not visibly soiled, an alcohol-based hand rub containing 60-90% ethanol or isopropanol can be used for all of the following situations: -After handling contaminated equipment. -After contact with inanimate objects (e.g., bed, curtains, bed rails. ect.) in the immediate vicinity	S 146		

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S 146	Continued From page 7 of the patient."	S 146		
S 221	44:75:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. These programs must be completed by all healthcare personel within thirty days of hire and annually thereafter, and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints and seclusion; (6) Patient rights; (7) Confidentiality of patient information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of patients with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of patients; (11) Advanced directives; and (12) Abuse and neglect. Any personnel whom the facility determines will have no contact with patients are exempt from training required by subdivisions (5), (8), (9), (10), (11), and (12) of this section. The facility shall provide additional personnel education based on the facility's identified needs. The facility shall make available current professional and technical reference books and periodicals for personnel. This Administrative Rule of South Dakota is not	S 221	All patients have the potential to be affected by this deficiency. No adverse effect has been noted. Dining assstiance, nutritional risks, and hydration needs of patients has been added to the nursing new employee orientation on 7/30/2024. All nursing staff have been assigned Nutrition for the patient - Healthstreams learning module as an annual assignment on 7/29/2024 with completion due date of 8/16/2024. Lifesource policy updates and procedure education provided to nursing staff at staff meetings 7/24/2024 and 7/25/2024. The new Organ,Tissues and Eye Procurement policy and expiration checklist provided and reveiwed with staff who signed acknowledgement. House Supervisors will ensure those not in attendance will recieve education prior to next shift. The Professional Development Coordinator or designee will monitor education compliance weekly and report monthly to the QAPI committee for follow up. The QAPI committee will review the results and if necessary make and recommendation for improvement. Monitoring results will be reported by the Professional Development Coordinator or designee to the QAPI committee and continued for no less than 3 months of monthly monitoring that demonstrates compliance then as determined by the committee.	08/20/2024

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S 221	Continued From page 8 met as evidenced by: Based on personnel file review and interview, the provider failed to ensure: *One of ten required trainings (dining assistance, nutritional risk, and hydration) was provided for six of six newly hired sampled employees (H, I, N, O, P, and Q). *Training related to the provider's Organ, Tissue and Eye Procurement policy was provided for six of six newly hired sampled employees (H, I, N, O, P, and Q). Findings include: 1. Review of employees H, I, N, O, P, and Q's New Employee Orientation Acknowledgement forms revealed it included: *Seven broad training categories. -Beneath each of those categories was a list of pertinent training topics. --There was a place beside each of those topics the employees initialed when they completed that training. *The required training topic "dining assistance, nutritional risk, and hydration" was not included on that form. Interview on 7/11/24 at 8:15 a.m. with chief nursing officer (CNO) B, registered nurse (RN)/Quality Assurance-Risk Management C, and Professional Development Coordinator R revealed: *They confirmed dining assistance, nutritional risk, and hydration was not included on the New Employee Orientation Acknowledgement form. -They were not aware that training topic was one of the nine State-required trainings expected to have been provided to new employees after they were hired and annually thereafter. 2. Interview on 7/9/24 at 1:45 p.m. with CNO B	S 221		

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regarding the provider's organ donation protocol revealed:
*A nurse supervisor was the contact person for general organ donation-related questions from family and the person responsible for contacting the organ procurement organization (OPO) to initiate the organ donation process.
-A designated nurse supervisor was available twenty-four hours a day, seven days a week.

Interview on 7/9/24 at 2:10 p.m. with RN L regarding the provider's organ donation protocol revealed she:
*"Sometimes" worked in the capacity of a nurse supervisor.
*Was provided no training related to the provider's organ donation protocol.

Interview on 7/9/24 at 4:30 p.m. with nurse supervisor H regarding the provider's organ donation protocol revealed:
*The organ donation protocol was "not yet defined."
*She had not known if the provider had an agreement with an OPO.
*She was provided no training related to her role and responsibilities as a nurse supervisor in regard to an organ donation protocol.

Interview on 7/10/24 at 8:55 a.m. with RN/nurse supervisor K regarding the provider's organ donation protocol revealed:
*She was the contact person for families who sought general information regarding organ donation.
-The provider's OPO, would be contacted and would speak with families about more detailed organ donation information and to initiate the organ donation process.
*She was provided no training related to her role

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S 221	Continued From page 10 and responsibilities in regard to organ donation. Interview on 7/10/24 at 10:10 a.m. with CNO B regarding organ donation training revealed she: *Thought organ donation-related training was a mandatory training offered through the on-line healthcare training program used by the provider. -Confirmed it was not included in the OPO's on-line training after reviewing her own on-line training transcript. *She would have expected organ donation training to be included in new employee orientation and annual employee training.	S 221		
S 231	44:75:04:10 Care Policies Each facility must establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the patients' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on memorandum of understanding review, interview, and policy review, the provider failed to ensure: *Their Organ, Eye, and Tissue policy supported their organ donation responsibilities outlined in the memorandum of understanding agreement established with the provider's organ procurement organization (OPO). Findings include: 1. Review of the 3/1/23 Organ, Eye and Tissue Recovery Memorandum Of Understanding (Agreement) between the provider and LifeSource (OPO) revealed:	S 231	All pateints have the potential to be affected by this deficiency, however, no deaths have occurred. The Nursing Organ, Tissue, and Eye Procurement policy has been update on 7/23/2024 to reflect the hospital duties to: designate a staff member to collaborate with Lifesource; timely notification to Lifesource post death; identification of Lifesource as contracted services for primary eye and tissue recovery agency. An expiration checklist was also added to the policy outlining the steps upon pateint death. The Chief Clinical Officer or designee will monitor all pateint deaths for timely notification to Lifesource, completion of the expiration checklist, and designated staff member was notified and collaborated with Lifesource.	8/20/2024

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S 231	Continued From page 11 *Page 5 of the agreement included the following "Duties of the Hospital [provider]" in relationship to the organ donation process: -4.1: Designating a staff member(s) to collaborate with LifeSource to "facilitate the development and implementation of an effective organ, eye and tissue donation program." -4.3: "Timely referral to LifeSource of all imminent deaths and all cardiac/circulatory deaths by calling LifeSource's 24 hour Donor Services Center, 800-24-SHARE." -4.17: Identification of LifeSource as the provider's primary eye and tissue recovery agency. -5: Development of written protocols and procedures to implement the provisions of the Agreement. Interviews on 7/11/24 at 8:55 a.m. and again at 10:55 a.m. with chief nursing officer (CNO) B and registered nurse(RN)/Quality Assurance-Risk Management C regarding the provider's 3/1/23 Agreement with LifeSource and the provider's September 2023 Organ, Tissue and Eye Procurement policy revealed their policy failed to: *Identify the staff person responsible for communicating with LifeSource about organ donation information and/or questions. *Identify the name of their designated OPO or how to contact them. *Make reference(s) to any written protocols and/or procedures appropriate to their organ, tissue and procurement program that were developed in collaboration with the OPO in accordance with the 3/1/23 Agreement.	S 231	The Chief Clinical Officer or designee will audit all patient deaths with monthly reporting to QAPI committee for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement. Monthly reporting will continue no less than 3 months audits that demonstrate compliance then as determined by the committee.	
S 233	44:75:04:12 Restraints Each facility must have written policies and	S 233	All patients utilizing wheelchairs have the potential to be affected by this deficiency.	

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S 233	Continued From page 12 procedures for all restraint use, including emergency restraints, bedrails, and locked doors. The use of restraints must be based on a comprehensive assessment of the patient's physical and cognitive abilities, evaluation and effectiveness of less restrictive alternatives, and an involvement of the patient in weighing the benefits and consequences. Restraint use requires a physician's, physician assistant's, or nurse practitioner's order specifying time frames and types of restraints. Continued use of the restraint and reorders may be given only by a physician's, physician assistant's, or nurse practitioner's order and a review of the patient condition by the interdisciplinary team. Restraints must be physically checked as ordered and documented by nursing personnel. Restraints may not be used to limit mobility, for convenience of staff, for punishment, or as a substitute for supervision. Restraints may not hinder evacuation of the patient during fire or cause injury to the patient. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to identify one of one sampled patient (7) seated in her wheelchair with the brakes locked in front of a countertop workspace was restrained. Findings include: 1. Observation and interview on 7/9/24 at 1:55 p.m. at nurses' station with nursing assistant (NA) I revealed: *Patient 7 sat calmly in her wheelchair in front of a countertop workspace with her wheelchair brakes locked. -Several magazines sat in front of her on the countertop. -A pillow was propped under the patient's right	S 233	Patients in wheelchairs were assessed to ensure they were not locked and restricted by pushing up to the countertop and not able to unlock wheels independently. Reeducation on restraint policy with emphasis on the definition of restraint being anything that may restrict or limit a patients mobility and the practice of assessing a patient's ability to unlock a wheelchair if put in front of the countertop thereby not restricting the patient was provided at nursing staff meetings on 7/24/2024 and 7/25/2024. Restraint policy was also reviewed with staff sign off. Nursing supervisors will provide education to those not in attendance prior to next shift. The Chief Clinical Officer or designee will audit all restraints and monitor education compliance. The visual audits will include: patient mobility, reason, type, alternatives attempted, care plan updated, provider order and nursing documentation per policy. All patients in wheelchairs will be observed and monitored. The Chief Clinical Officer or designee will report the audit findings to the QAPI committee for follow up. The QAPI committee will review the audits results and if necessary make any recommendation for improvement. Audits will be reported monthly for no less than 3 months of demonstrated compliance then as determined by the committee.	08/20/2024

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arm and an alarm was attached to her wheelchair cushion.
*NA I sat along the side of the patient faced in the opposite direction of the patient.
-She used the computer in front of her as she spoke to the patient.
--The patient communicated in a manner that was not understandable.
*NA I confirmed the patient's wheelchair brakes were locked because she was impulsive at times and her cognitive impairment increased her risk for falls.
*There was a video camera in the patient's room used for that same reason.
-A video monitoring screen at the nurses' station was expected to be checked by staff no less than hourly when the patient was alone in her room.
*At 2:05 p.m. NA I was relieved from monitoring patient 7 by certified nursing assistant (CNA) S.

Continued observation and interview with CNA S revealed:
*Patient 7 was monitored by staff unless she was with therapy staff or her family was visiting.
*The patient sat in front of the countertop work space with her wheelchair brakes locked because she was at risk of bending over in the wheelchair and falling.
*Patient 7 remained at the nurses' station in the position described above with staff monitoring her until 4:30 p.m. when a family member arrived.

Interview on 7/10/24 at 10:45 a.m. with registered nurse (RN)/nurse supervisor K regarding the above observations of patient 7 at the nurses' station revealed:
*She confirmed positioning the patient in front of the countertop workspace with her wheelchair brakes locked was a restraint.
-The patient was unable to release the wheelchair

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brakes herself and move herself away from in front of the desktop on her own.
*She stated here was no need to lock the wheelchair brakes when the patient was cooperative, staff was available, and she had a chair alarm.

Observation and interview on 7/11/24 at 12:25 p.m. with unit secretary/clerk T at the nurses' station revealed:
*Patient 7 was seated in her wheelchair behind the nurses' station in front of the countertop workspace with her right wheelchair brake locked.
-She was feeding herself pizza for lunch.
*The patient was calm and had not attempted to move her wheelchair or unlock her brakes.
*Unit secretary/clerk T sat beside her.
-She stated the patient's wheelchair brake was locked and she was eating her lunch there because "she needs [staff] supervision."
-She agreed there was no need for the patient's wheelchair brakes to have been locked when she was supervised and had not attempted to move the wheelchair on her own or tried to stand up.

Interview on 7/11/24 at 1:25 p.m. with CNO B and RN/Quality-Assurance Risk Management staff C revealed they:
*Had not known if patient 7's ability to lock and unlock her wheelchair brakes independently had been assessed.
*Had not known what other less restrictive interventions were tried before locking the patient's wheelchair brakes.
*Agreed patient 7's freedom of movement was restricted and that was a restraint.

Review of patient 7's care plan last revised on 6/22/24 revealed:
*Fall interventions included wearing non-skid

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S 233	Continued From page 15 socks and the use of bed/chair alarms as needed. -There was no mention of the level of staff supervision she required when she was not with caregivers or her family. -There was no mention of locking her wheelchair brakes while in front of the nurses' work station to prevent her from moving her wheelchair or attempting to stand up on her own. Review of the provider's December 2023 Restraint Use policy revealed: "Restraints are ordered and applied by trained personnel in response to emergent, dangerous situations as an adjunct to planned care. The decision to use a restraint is driven not by diagnosis but by a comprehensive individual assessment concluding that for this patient at this time, the use of less restrictive measures poses a greater risk than the risk of using a restraint."	S 233		
S 253	44:75:06:04 Patient Care Plans and Programs The facility shall provide nursing services that are safe and effective from the day of admission through the ongoing development and implementation of a written care plan for each patient. The care plan must address medical, physical, mental, and emotional needs of the patient. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to develop and revise individual care plans to reflect the care needs of six of twenty sampled patients (1, 2, 4, 5, 7, and 8). Findings include:	S 253	All patients have the potential to be affected by this deficiency. All patient charts were reviewed to ensure care plans were accurate and updated. All nursing staff were educated on care plans and policy at staff meetings on 7/24/2024 and 7/25/2024. All staff signed acknowledgment of policy Nursing - CarePlanning. The education included ensuring interventions where populated to the TAR so staff would be reminded to document and update as patient care needs changed. Nursing supervisors will provide education to those not in attendance prior to the next shift. The Chief Clinical Officer or designee will monitor education compliance.	08/20/2024

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S 253	Continued From page 16 1. Interview on 7/9/24 a.m. with patient 4 revealed: *He was hospitalized after having a stroke then discharged to a local skilled nursing facility (SNF). -He was transferred from the SNF to the inpatient rehabilitation facility (IRF) for a more aggressive therapy program than the SNF was able to offer. *He planned to return home with his wife when he was discharged from the IRF. Review of patient 4's electronic medical record (EMR) revealed: *His admission date was 6/27/24. *In addition to a stroke his other diagnoses included diabetes, sleep apnea, dysphagia, hypertension, and atrial fibrillation. *He required intermittent staff supervision during meals and had a home CPAP (continuous positive airway pressure) machine but preferred not to use it at the IRF. Review of patient 4's care plan last revised on 6/29/24 revealed: *No goals related to discharge planning, required mealtime supervision or respiratory care. *An incomplete bowel intervention: "Administer _____ [blank space] medication as ordered by physician." 2. Interview on 7/9/24 at 10:45 a.m. with patient 1 revealed: *He was discharged home from a hospital after a left total knee arthroplasty (TKA). -He had problems with his blood pressure after he got home and he was readmitted to the hospital. *He was discharged to the IRF after his subsequent hospital stay. *He had a history of sleep apnea and used a CPAP.	S 253	Nightly chart audits will be completed by the House Supervisor, 14 audits per week to include: care plan individualized, updated after every IDT meeting if changes needed by nursing staff or case managers with interventions on TAR, and TAR completed each shift. They will be reviewing care plan as a whole to meet standard, including nursing, therapies and case managment. These audits have been added to nightly shift duties of the house supervisor. The Chief Clinical Officer will report audit findings monthly at QAPI for follow up. The QAPI committee will review the audit results and if necessary make any recommendations or improvement. Audit results will be reported by the Chief Clinical Officer or desginee to QAPI and continued for no less than 3 months of monthly audits that demonstrate sustained complaince then as determined by the committee.	

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*His pain level was acceptable.
-He received scheduled and as needed pain medication.

Interview on 7/9/24 at 11:00 a.m. with registered nurse (RN) L regarding patient 1 revealed he was expected to be discharged home with his wife this week.

Review of patient 1's EMR revealed:
*His admission date was 6/25/24.
*In addition to a TKA his other diagnoses included a history of malignant prostate cancer, urogenital implants, and dysuria (painful urination).
*He was diabetic and his blood sugars were regularly checked.
*He was provided a Heart Healthy diet.

Review of patient 1's care plan last revised on 7/2/24 revealed:
*No goals related to discharge planning, diabetic management, his special dietary needs, or respiratory care.
*Incomplete interventions for the following:
-Pain management: "Administer pain medications/analgesics _____ [blank line] minutes before therapy."
-Skin care management:
-"Dressing change to incision(s) _____ [blank line] per day per physician order."
-"Assess wound(s) and/or incision(s) every _____ [blank line] for signs or symptoms of infection."

3. Observation and interview on 7/9/24 at 1:55 p.m. with patient 7 and nursing assistant (NA) I at the nurses' station revealed:
*The patient was seated calmly in her wheelchair in front of a countertop workspace with her wheelchair brakes locked.
*NA I sat along the side of the patient faced in the

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opposite direction of the patient.
*She confirmed the patient's wheelchair brakes were locked because she was impulsive at times and her cognitive impairment increased her risk for falls.
-There was a video camera in the patient's room used for that same reason.
*The video monitoring screen was expected to be checked by staff no less than hourly when the patient was alone in her room.

Review of patient 7's EMR revealed:
*Her admission date was 6/21/24 and her diagnoses included a recent stroke, aphasia (trouble communicating), and cognitive impairment.
*She was recently treated with an antibiotic for a urinary tract infection.
*She required staff assistance and monitoring during mealtimes for safety.
*Referrals were made to skilled nursing homes for placement after she was discharged from the IRF.

Review of patient 7's care plan last revised on 6/22/24 revealed no goals related to discharge planning, staff supervision during meals or urinary tract infection prevention interventions.

4. Review of patient 2's EMR revealed:
*Her admission date was 6/11/24.
*She had fallen and broken the shaft of her femur and a left pelvis fracture.
*She was admitted from an acute care setting to the IRF for a more aggressive therapy program after surgical repair of the fractured femur.
*Her goal was to return home and to her prior level of function.
*During her hospitalization at the IRF she had:

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-Required a blood transfusion due to a low hemoglobin blood count.
-Experienced a significant weight loss and required additional protein and calorie changes to her diet.

Review of patient 2's 6/11/24 care plan revealed:
*An initial care plan had been developed on her admission date of 6/11/24.
*On 6/12/24 her care plan was updated and supported her at risk for falls and alteration with activities of daily living (ADL) related to:
-Her history of falls, hypotension (low blood pressure), seizure (uncontrolled bodily movements), and dizziness.
-The left femoral fracture and her decline with ADL.
*On 6/13/24 her care plan was updated to support a problem with her mobility due to the left femoral fracture.
*There was no further documentation that her care plan was updated that supported her changes during her hospitalization from 6/11/24 through 7/9/24.
*There were no problem areas in her care plan that supported she had required assistance with:
-Discharge planning to ensure a safe transition back to her home environment had occurred and outside services such as home health.
-Nutritional support and monitoring due to her weight loss while hospitalized at the IRF.
-Monitoring the diagnosis of anemia and the requirement for a blood transfusion during her hospitalization.

5. Observation on 7/9/24 at 3:48 p.m. of registered nurse/nurse supervisor (RN) H during a dressing change for patient 5 revealed:
* The patient had been awake and lying in her bed resting.

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S 253	Continued From page 20 *RN H had prepared to complete a dressing change to her peripherally inserted central catheter (PICC) line on her right upper arm. *Patient 5 had required assistance from the nurse for repositioning in her bed. *During the dressing change discussed how her back surgery went and her progress. *She had received a new back brace on 7/5/24 and could not wait until she no longer required the use of it. Review of patient 5's EMR revealed: *Her admission date was 7/1/24. *She had been admitted from an acute care setting to receive more aggressive therapy and support while she regained her strength from back surgery. *Her admitting diagnoses included: spinal fusion of the thoracic area spanning from T2 through T10, high blood pressure, chronic kidney disease, anxiety, depression, osteoporosis, and kyphosis (curvature) of the thoracic spine. Review of patient 5's 7/11/24 revised care plan revealed: *The 7/11/24 revision to her care plan had supported the insertion of the PICC line for antibiotic treatment. *There were no other revisions to the care plan that supported her current capabilities and interventions from admission on 7/1/24. *There was no discharge planning in place to ensure a safe transition back to her home. *Her ADL status had not been updated since her admission to support what she needed assistance with from the staff. *There were no problems, goals, or interventions in place related to the use of the back brace regarding: -How it was to be used.	S 253		

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S 253	Continued From page 21 -When she was required to wear it and when she could have it off. *She had an alteration in her mobility due to chronic back pain. -There were no interventions that supported how the staff were to assist her to transfer safely or what equipment was required to meet her mobility needs. 6. Observation on 7/10/24 at 9:00 a.m. of patient 8 revealed: *She had been awake and lying bed resting. *The staff had prepared to assist her with ADLs and transferring out of her bed into a high back wheelchair (w/c). *She had a neck brace on and could hardly speak due to her mouth having been wired shut. *Her right arm and leg had limited movement. *She: -Required the use of a torso brace when out of bed. -Required three staff members to assist her with transferring into the high back w/c. -Was able to stand for a limited amount of time due to her increased weakness and limited range of motion (LROM). -Was dependent upon the staff to meet all of her ADLs and develop a plan of care that met all of her needs. -Was not able to brush her own teeth or take a drink of water. *Her diet was limited and had to be liquefied in a blender due to her mouth being wired shut. -The staff had to assist her with eating and drinking through the use of a syringe. *There had been a pair of wire cutters hanging on the wall in case she required her wires to be cut in an emergency. Review of patient 8's EMR revealed:	S 253		

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S 253	Continued From page 22 *Her admission date was 7/5/24. *She had been admitted from an acute care setting to the IRF for a more extensive rehab and therapy program. *On 6/15/24 she had been in an accident and had injuries that included: -Closed fractures on the left side of her mouth that had required being wired shut. -Closed fractures of her spine that had required fusion. -Closed fracture of her right fibula. -Multiple closed fractures of her pelvis. Review of patient 8's 7/5/24 through 7/6/24 initial care plan revealed: *There was no discharge planning initiated to ensure her goals to return home would have been met. *Her activities of daily living (ADL) status had not been updated since her admission to support what she needed staff assistance with such as: -Eating and drinking through a syringe and by assistance from the nursing staff. -The use of a neck and back brace for when she was out of bed. *There were no problems, goals, or interventions in place to support the use of the neck and back brace including: -How they were to be used. -When she was required to wear them and when she could have them off. *She had an alteration in her mobility due to chronic back pain. -There were no interventions that supported how the staff were to assist with safe transfers and what equipment was required to meet her mobility needs. *There was a problem with her nutritional status due to her jaw being wired shut. There were no interventions that supported:	S 253		

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-How the staff were to help her with eating.
-What consistency her food should have been for safety from aspiration.
-What the cutters were to be used for.
*There were no problems, goals, and interventions that supported:
-Her recent onset of Norovirus (highly infectious acute illness) and what precautions had been in place for other patient's and staff's safety.
-The interventions and isolation precautions that were required to safely take care of her during the acute illness.
*Her care plan did not address the safety risks involved with her oral care.
-There was no documentation to support her oral care was to have been completed by the nurses due to the risks of aspiration.
-She had required suctioning during the process of her oral care.
*There was no documentation that supported the use of a video monitoring camera to ensure she remained safe from aspiration when the staff were not present in her room.

Interview on 7/11/24 at 11:05 a.m. with RN J regarding patient 8's care plan revealed she:
*Had admitted the patient and initiated her care plan.
*Confirmed:
-Patient 8's care plan had not been updated since the patient had been admitted.
-Other staff had the capability to update her care plan.
-The care plan had the capability for the staff to individualize it to meet the patient's needs.
*Agreed the care plan had not addressed the patient's:
-Nutritional status and the process for assisting her with eating.
-Special needs for assistance with all ADLs to

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include oral care, brace use, bed mobility, transfers, and personal care.
-Goals and interventions for discharge planning.
-Safety risks involved with the extent of her injuries and her jaw being wired shut.
-Use of video monitoring to ensure she remained safe when alone in her room.
*Would have used an internal report sheet to take care of the patients versus the care plans.
*Stated: "I don't even look at the care plan before I take care of a patient. I use what we call the brains sheet to take care of them."

Interview on 7/11/24 at 1:20 p.m. with chief nursing officer N and RN C regarding care plans revealed:
*They would have expected the staff to update the patient's care plans to reflect their current level of care.
*The nurses should have updated them every shift or at a minimum reviewed them to ensure they remained current to meet the patient's needs.
*There should have been a date to support when they were reviewed or resolved.
*They would have expected was the supervisors to have updated the primary care nurses on any care plan changes for the patients after their weekly interdisciplinary team meetings.
-The primary care nurses should have updated the care plans to reflect those changes from those weekly team meetings.

Review of the provider's September 2023 Care Planning policy revealed:
*"Care treatment and services are planned to ensure that they are individualized to the patient's needs.
*The Hospital shall provide an individualized, interdisciplinary plan of care for all patients that

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REHAB & CRITICAL CARE HOSPITAL OF THE BLACK	2115 PROMISE ROAD RAPID CITY, SD 57701

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S 253	Continued From page 25 are appropriate to the patient's needs, strengths, results of diagnostic testing, limitations, and goals. *Nursing staff shall develop a plan of care for each patient with 24 hours of admission. *Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the patient that are reasonable and measurable. *The activities defined in the plan of care shall be planned to occur in the time frame that meets the healthcare needs of the patient. *The plan of care is maintained and updated based upon ongoing patient assessments and the patient's response to care, treatment and services. *The plan of care will be documented through the use of computerized care planning." *Procedure: -"The plan of care shall be individualized, based on the diagnosis, patient assessment and personal goals of the patient and his/her family. -"Care planning is based on data collected from patient assessments with integration of those assessment findings in the care planning process. -Developing a plan for care, treatment and services that includes patient care goals that are reasonable and measurable. -The needs f the patient, goals, time frames, required services and the service settings are critical considerations in determining the plan for care. -Regularly reviewing and revising the plan for care, treatment and services. -Determining how the planned care, treatment, and services will be provided. -The plan of care will be individualized to the needs of the patient.	S 253		

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S 253	Continued From page 26 -The plan of care shall include input of other disciplines, as appropriate. -The plan of care will be continually evaluated based on the patient's clinical condition, results of diagnostic tests, care goals and the plan for treatment, care and services, and revised as needed to meet the needs of the patient's changing condition. -Patients and/or families are involved in care planning." -"All staff using the computerized plan of care are responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions."	S 253		
S 261	44:75:07:02 Food Safety Hot food must be held at or above one hundred thirty-five degrees Fahrenheit or 57.2 degrees centigrade and served promptly after being removed from the temperature holding device. Cold foods must be held at or below forty-one degrees Fahrenheit or five degrees centigrade and served promptly after being removed from the holding device. Milk and milk products must be from a source approved by the state Department of Agriculture and Natural Resources. Fluid milk must be Grade A, and only fluid milk may be used for drinking purposes. Grade A pasteurized dried milk may be used to fortify nutritional supplements only if consumed within four hours of preparation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, testing, and policy review, the provider failed to ensure: *One of one stainless steel cold pan serving unit held cold food at 41 degrees Fahrenheit (F).	S 261	All patients, visitors and staff have the potential to be affected by this deficiency. Cafe food line temperature log was created by the Dietary Manager on 7/11/2024. Staff education occured on 7/12/2024. All dietary staff also completed Time and Temperature Inservice with Quiz. All prepared food items for to-go where moved into a temperature monitored fridge and removed from steam table area on 7/12/2024. The Dietary Manager or designee will monitor daily and maintain the daily cafe temperature log and provide the temperature logs to the QAPI committee monthly for review and if necessary make any recommendations for improvement. Logs will be provided for no less than 3 months of demonstrated sustained 100% compliance then as determined by committee.	08/20/2024

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S 261	Continued From page 27 *Temperatures of both the cafeteria steam table and the cold pan serving unit had been monitored. Findings include: 1. Observation and interview on 7/9/24 at 11:35 a.m. of dietary manager D revealed she: *Had brought food out from the kitchen steam table. The shrimp scampi was 157 degrees F. and the rice was 153.8 degrees F. *Did not document those temperatures anywhere during the observation. *Stated they did not take the temperatures of the food when it was brought out as it was already hot from the kitchen steam table. 2. Observation on 7/9/24 from 11:30 a.m. through 11:45 a.m. of the cold pan serving unit revealed: *It contained ready-to-eat items including: -One bacon, scrambled egg, and cheese wrap. -Two sausage, scrambled egg, and cheese wraps. -Two vegetable, scrambled egg, and cheese wraps. -The wraps had all been made on 7/8/24. -The temperature of those wraps was 56.4 degrees F. -Two containers each contained a hard boiled egg, sliced turkey, and cheese cubes, -The containers had been put together on 7/5/24. -The temperature of the hard-boiled eggs was 55.9 degrees F. *The other part of the cold pan serving unit contained a salad bar. *The ingredients of the salad bar were in separate plastic containers. -Those containers were approximately four inches about the cooling surface of the serving unit. *The salad bar contained food items that	S 261		

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included:
-Hard-boiled eggs with a temperature of 46.7 degrees F.
-Cucumber slices with a temperature of 42.4 degrees F.
-Other food items were tomato slices, bacon bits, sliced black olives, grated cheese, slices of red and green peppers, and iceberg lettuce.

Interview on 7/9/24 at 12:00 p.m. with dietary aide E revealed he:
*Was not sure of what the temperature the cold pan holding unit should have been.
*Did not take the temperature of the food items before or after it had been placed or removed from the cold pan holding unit.
*Stated if the food was in the refrigerator at 40 degrees F the food would stay at 40 degrees F after it was placed in the cold pan holding unit.

Interview on 7/9/24 at 12:15 p.m. with dietary manager D and confirmed:
*The food above was stored in the kitchen refrigerator when it was not in the cold pan serving unit.
*There were no dates on the containers of when the food had been placed in them.
*The temperatures of the above foods were not monitored.
*The cold pan serving unit thermometer was set at 36 degrees F.
*She did not realize the food in the cold pan serving unit was not close to the surface of the unit to maintain a holding temperature of 41 degrees F.
*The food in the cold pan serving unit was available to patients, staff, and visitors.
*If a patient wanted a salad, it was made up from the ingredients on the cold pan serving unit.
*The food temperatures from the cafeteria tray

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S 261	Continued From page 29 line were not taken and not documented. Review of the provider's November 2023 Hazard Analysis and Critical Control Program (HACCP) Standards policy revealed: *"Food and Nutrition Services utilizes the following critical control monitors on a regular basis to address and analyze food safety, quality and prevent foodborne illness during procurement, handling, production and service of food." -Those critical control monitors included trayline food temperature logs, food cooling logs, and taste/temperature monitor/point-of-service monitor. *The Manager, Food and Nutrition Services advises staff of monitor findings and immediately documents and addresses any nonconformance with standards, immediate actions taken, performance improvement, staff counseling, education and training conducted including target date and follow-up of nonconformance noted." Review of the provider's February 2023 Food:Preparation policy revealed: *"Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination." *"The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed temperatures greater than 41 degrees F and/or less than 135 degrees F per state regulation." *"All foods will be held at appropriate temperatures, great than 135 degrees F (or as state regulation requires) for hold holding, and less than 41 degrees F for cold food holding." *"Temperature for TCS [temperature control for	S 261		

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S 261	Continued From page 30 safety] foods will be recorded at time of service, and monitored periodically during meal service periods." *"All refrigerated ready-to-eat TCS prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date" (Day 1) and a "use by date" (Day 7)."	S 261		
S 270	44:75:07:10 Preparation of Food Food shall be wholesome and prepared by methods that conserve nutritive value, flavor, and appearance and shall be attractively served at the temperature applicable to the particular food in a form to meet the individual patient's needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one observed cook (F) had maintained the nutritive value of food when pureed food items. Findings include: *Observation and interview on 7/9/24 at 11:24 a.m. of cook F revealed she added water and a small amount of chicken base powder with the broccoli and rice that was pureed. She was not aware she should have used something that maintained the nutritive value of the food. Review of the provider's February 2023 Quality and Palatability policy revealed "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature."	S 270	All patients with alternative consistency diet requirements. Food preperation training was provided to the Kitchen staff by dietary manager with specific to Texture Modifications on July 12, 2024. The Dietary Manager or designee will audit food preperation to ensure compliance with policy and procedure. A minimum of 10 meal preperations per week will be audited. The Dietary Manager or designee will report audit findings to QAPI monthly for follow up. The QAPI committee will review audit results and if necessary make any recommendation for improvement. Montoring of results will reported to QAPI for no less than 3 months that demonstrate sustained compliance then as determined by the committee.	08/20/24

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