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	430077	A. BUILDING _____ B. WING _____	C 10/04/2023

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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 10/3/23 through 10/4/23. Areas surveyed included patient rights, pharmaceutical services, nursing services, and quality assurance. Monument Health Rapid City Hospital was found not in compliance with the following requirement: A489.	A 000		
A 489	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on review of the South Dakota Department of Health (SD DOH) complaint intake information, observation, interview, and policy review, the provider failed to review the security processes for controlled substances and identify the need for staff re-education following the misappropriated use of controlled medications in one of one intensive care unit (ICU) by one of one registered nurse (RN) (K). Findings include: 1. Review of the provider's 8/31/23 final incident	A 489	Senior Director Pharmacy Operations, Director Pharmacy, Pharmacy Quality Consultant, and Associate General Counsel of Legal Services developed a formalized investigation report form to be used when a drug diversion has been identified. The form includes the review of current medication security processes to ensure no system failures or enhancements are needed, review of policies and procedures for changes to ensure the safe destruction and handling of controlled medication occurred, and review of annual education for any revisions necessary. The investigation report form will be completed by November 18, 2023. This team will be utilizing the form so no formal education will be completed. Senior Director Pharmacy Operations, Associate General Counsel of Legal Services, VP Quality Safety Risk Management, Director Pharmacy, Director of Nursing-ICU reviewed the Drug Free Workplace and Drug Diversion Guidelines policy. Revisions include the following: process when a suspected drug diversion is identified, identify the staff involved in the resolution process of a suspected drug diversion to include Quality, Safety, and Risk	11/18/2023

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

Jeri Fine | V.P. Quality, Safety, Risk Management | 11-2-23

An 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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A 489	Continued From page 1 report investigation submitted to the SD DOH on suspicion of misappropriation of controlled medications (med) by RN K revealed: *He had been employed since 6/13/23 and worked in the ICU. *On 8/29/23 a concern for diversion was triggered in reference to RN K. *He had removed thirteen vials of Fentanyl (a controlled opiod liquid pain med) 50 microgram (mcg)/milliliter (ml) from the Omnicell (automated med dispensing unit) on a single overnight shift from 8/27/23 through 8/28/23. *Medical record review of the patient's that he had cared for during that overnight shift revealed the following: -Multiple vials had been pulled that were not administered to the patients and were outside of the patient's physician order parameters. -Two administrations of Fentanyl were pulled within two minutes of each other with no medication waste documented. *The excessive med pulled and improper documentation had prompted an investigation into RN K for possible drug diversion. *RN K: -Consented to have a drug test completed. The results from that test were positive for opiates. -Was unable to reconcile the discrepancies in the documents that were presented to him for review. -Admitted to taking Fentanyl from the hospital for his own personal use and was terminated for drug diversion. Continued review of the provider's 8/31/23 final incident report investigation submitted to the SD DOH revealed: *The provider had not: -Reviewed the current med security processes to ensure there was no system breakdown or	A 489	Management, root cause analysis review, and process change(s) if needed. Drug Security and Storage policy was reviewed and revised to include pharmacy involvement in education upon hire, annual, and as needed regarding drug diversion. Policy changes will be made and approved by November 6, 2023. Senior Director Pharmacy Operations, Associate General Counsel of Legal Services, VP Quality Safety Risk Management, Director Pharmacy, Director of Nursing-ICU reviewed current drug diversion education and revised education to be provided upon hire and annually to caregivers (including travel nursing) and providers that have contact with medications. Travel nursing education was reviewed and revised to be included in education upon hire. Education will include signs and symptoms of drug diversion, escalation process, and the updated policies: Drug Free Workplace and Drug Diversion Guidelines. Education will be completed by the following caregivers; inpatient nursing (including any traveler on assignment during this time), emergency department nursing, paramedics, and providers, surgery nursing and CRNAs, procedural nursing (Cath Lab, Interventional Radiology, Endoscopy), Anesthesiology, Inpatient Hospice, and Pharmacy by November 18, 2023. Any caregiver or provider on leave will be required to complete the education prior to the first worked shift. Monitoring: Department Director or designee will monitor education completion and report to the Vice President of Quality, Safety, and Risk Management and VP with department oversight by November 18, 2023. Monitoring	

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A 489	Continued From page 2 enhancements to the controlled drug security process required. -Reviewed the policies and procedures for changes or updates to ensure the safe distribution and handling of controlled medications occurred. -Required re-education to the staff on those policies and procedures for drug diversion to ensure understanding of them. *"Our drug diversion system/process worked as designed and lead to an appropriate intervention in a timely manner." *"Staff have been educated on drug diversion in nursing orientation. At this time, the ICU does not have a plan to education [educate] current staff as this was recently the only RN termination and would easily be linked to the terminated caregiver." *"Current policies including signs of diversion, signs of impairment, policy enforcement, reporting to appropriate boards, reporting to DCI [Division of Criminal Investigation], and termination are covered during nursing orientation." *"Our system identified the diversion in 6 weeks which is better than the national average." *"We do not feel 6 weeks is a long time to identify diversion." 2. Interview on 10/3/23 at 10:52 a.m. with RN D on the ICU revealed: *She had worked for the provider for some time and specifically in the ICU. *She was well aware of the processes for controlled medication retrieval, administration, and destruction processes. *To her knowledge there had not been any recent changes to the current policies and processes. *Outside of the required annual drug diversion	A 489	will continue until all previously identified caregivers and providers have completed education to include those on leave at the time of education.	

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A 489	Continued From page 3	A 489		

training, there had not been any re-education.
*She stated:
-"We would have received an email on any additional trainings they wanted us to do."
-"I don't recall seeing any emails about that."
-"But you might be better off asking [staffs name], she keeps up on that stuff better then I do."
-"I tend to just skim my emails."

3. Interview on 10/3/23 at 11:18 a.m. with RN E on the ICU revealed:
*She had worked for the provider for approximately eleven years and had recently switched to as needed (PRN).
-All of her work history had been on the ICU.
*She was not aware of any recent education opportunities or training involving med security and drug diversion.
*She stated: "Nothing besides our annual iLearn [annual online training] requirements."

4. Interview on 10/3/23 from 1:00 p.m. through 1:30 p.m. with RN A revealed:
*She was new to the ICU director position and the incident with RN K had been her first drug diversion investigation.
*She had clinical resource nurses (CRNs) on the unit that were a part of the staffs orientation and training.
*She stated: "The normal training and orientation for ICU is six weeks."
*RN K had worked at the hospital in the past and everyone talked very highly of him and looked forward to his return.
*RN F:
-Was the CRN that had been a part of his orientation and training process.
-Had not worked with him in the past and had concerns with his behavior towards the end of his

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A 489	Continued From page 4 orientation. -Had sent an email to RN A on 7/22/23 regarding his behavior and informed her that she [RN F] had provided a coaching session to him via an email at the end of the shift. -Had been concerned because he was ending his orientation period. *She stated: -"[RN F's name] was concerned because he was off the unit a lot and could not be found." -"She coached him the next night on her concerns and felt he took it well because there were never any issues with him again." -"His patients were always well cared for and any [patients] that were interviewable talked highly of him." -"This happened over a weekend and right away on Monday morning [controlled substance coordinator C's name] called concerned because he had six vials of Fentanyl missing during that one shift." -"We had been watching him some because when looking at his pain scores twelve hours before his shift and twelve hours after his shift, his scores were way higher than anyone else's. It was gradual though until that night." -"It's not uncommon to have orders for PRN Fentanyl every hour for pain control. Which is what he was using." -"His documentation that night was very poor and hard to follow." -"When we interviewed him [on 8/29/23], he stated "I don't know a lot. Sometimes I would put the med in a locked drawer because the patient had C-Diff [Clostridium difficile] [infectious disease that spreads easily] and thought he might need it at some point. I don't normally do that. I don't know where the unused vials are." -"He shared how he was putting saline back in	A 489		

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A 489	Continued From page 5 the syringes and that's what he wasted." -"Towards the end of the interview he finally confessed to taking them for his own personal use." -"The coaching sessions were like a verbal warning and only stay in the employee's file in the area that they work. It doesn't go to human resources at that point." -"There's no other formal document for it besides the email from [RN F's name]." Interview on 10/3/23 at 1:30 p.m. with RN A regarding the drug diversion regarding RN K revealed: *There had not been any re-education on drug diversion or security of controlled medications for the staff after the incident with RN K. *To her knowledge, the pharmacy had not required any re-education/training or review of the drug security and diversion policies. *She stated: -"If I had to educate the staff it would be on that they are to draw-up and waste at the same time, not wait." -"He [pharmacy director B] comes to every onboarding [new employee orientation] and reviews their processes in pharmacy. It includes drug diversion." -"He tells them how he will catch them [diverting drugs] if they do and the processes they have in place." -"Last week I had a meeting with the CRNs and discussed making good choices because choices have consequences." -"I talked briefly about if they suspected anyone diverting to report as soon as possible. Also about late outs and missed lunches." -"He had a lot of late outs and missed lunches, but honestly, if I had to compare his to everyone	A 489		

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A 489	Continued From page 6 else in ICU, it wouldn't flag a concern because this is typical." -"Also I have started looking at the scanning of meds, I get a report or bedside verification on this weekly from pharmacy. But this was in place prior to the diversion." -"I can't tell you what had been done after the diversion, all I can tell you is what I am doing and I am watching my staff more for increase in absences, my CRNs are rounding on all nurses every shift." -"We already have a lot of catches in place, so honestly I don't know what I'd do differently." -"When we coach someone, that information just stays within our department. Not severe enough for human resources to be involved yet. A first offense type thing." 5. Interview on 10/3/23 at 2:00 p.m. with RN F revealed: *She worked in the ICU as a CRN or a floor nurse. *As a CRN she was required to be available to assist the staff as needed and do rounding on them during the shift to make sure there were no concerns. *She confirmed: -RN K had six weeks of orientation and she had been a part of that process. -She had concerns with his behavior and work performance during the orientation. -She had emailed her director about what occurred during one of her shifts and how she had coached him on it. *She stated: -"Reflecting back and knowing what I do now, yeah, there were a lot of signs of drug diversion." -"I have never worked with him before and those who did were so excited about him coming back."	A 489		

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A 489	Continued From page 7 -"So I wasn't sure if maybe something had gone wrong with his orientation?" -"But he was gone frequently from the floor and would not tell anyone. That is a big no! You never leave the floor without telling someone." -"I thought he was in our room that we call a garage. It has tons of supplies and you can literally stand in it for hours looking for stuff." -"Or I thought maybe he was having bowel issues." -"He was frequently diaphoretic and more sweaty lately." -"His documentation was bad and he was late with some antibiotics and I just thought it was being new again." -"We recently had a meeting and discussed if he could progress to learning more equipment and I thought he needed more time." -"He was very quiet and reserved so he was hard to gauge. All he told me was he had a lot going on in his personal life and didn't think using his phone on the floor was appropriate." -"I did some coaching with him on my concerns and to be honest, I didn't have an issue with him after that." -"No, we've not had any re-education on drug diversion or security of meds. We probably should because everything is just based off of trust anymore." -"We do have standards in place but improvement with wasting would be good." 6. Review of the 7/22/23 internal email exchanged between RN A and RN F regarding RN K revealed: *RN F: -Had worked with RN K on 7/21/23 and had several concerns regarding his behaviors. -Had emailed RN A what had occurred while	A 489		

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A 489	Continued From page 8 working with him that night. *In the email RN F wrote: "I don't know if he's just off yesterday or what the deal was but I was spending more time looking at his charting and there were some serious issues. He [here] are some things that concern me: -1. He is frequently late, almost clocks in every single shift a min [minute] or two late. He was late almost 2 hours one day and I wanna say just didn't show up for his shift another day. -2. He disappears from the unit all the time. It was an issue yesterday, OR [operating room] was trying to call for report on a patient that he knew he was getting and no one could find him. I don't know if it's a GI [gastro-intestinal] thing or personal thing but he can't just disappear all the time without telling his coworkers what's up. -3. Multiple antibiotics were over an hour late. I kept asking him if he need [needed] help and [he] kept refusing. Finally I just stepped in and hung one and another one walked it into the room for him to hang. -4. I asked him if he used his brain [computer program] and his response was yes. I talked about how convenient it was to use for lab draws and keeping on time with med, knowing what to chart on. Hint Hint. He still failed to draw a stat lactate and I once again walked the supplies into the room and asked if he saw they ordered them once it was almost an hour late. -5. Our patient's blood pressure [b/p] was getting soft [low] so I turned back on the vaso [vasopressor] while he was pulling meds and told him. Over the next 15 or so min [minutes] tanked [b/p dropped critically low]. I walked into the room and asked if that was real and he was messing with an IV [intravenous] or something. He looks up and calmly says he thinks so. He restarts the levo [levophed] [med that makes the veins	A 489		

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A 489	Continued From page 9 squeeze tighter to increase the b/p] at only 4. I said hey I think you might be better at just letting things ride than I am but that makes me really nervous. Crank that! we had to go up to 14 of levo eventually, because he was just letting it ride. I asked if he had ever called gen surg [general surgery] about the wound vac [device to assist with wound healing] output (which I had been commenting on how much it was for a couple hours, once again a hint) and he said he hadn't had a chance to, so I had to call gen surg and ICU about the BP [b/p] issues. His response time to the situation made me very nervous. He thanked me multiple times for saving him. I don't know if it was meant just to be nice, cause he's a really nice guy, or if he was in over his head. -6. At the end of the shift I was trying to power chart to get us caught up. I ended up leaving at 1930 [7:30 p.m.] and [staff name] said she has no clue what time he left. I charted I'd guess more than 50% of the things on our patients. It was not a busy shift by any means and there is no reason why he shouldn't have had everything charted on. When I had done all that I could for charting I told him ok you just have assessments, vitals and end of shift note to do on 259. When I came in today I saw that he didn't do any of those, so currently he did not chart a single vital or assessment all shift on 259. -7. As for the vitals on 259 I looked on the monitor to try to pull them so I could validate them and he had only gotten them at 1130sih [11:30 a.m.] and 1330ish [1:30 p.m.]. I told him at 1600 [4:00 p.m.] hey I don't know if you saw the 1600 blood pressure on 259 didn't cycles. He said oh I'll go get it and just never did. When it came time to leave I told him I tried to validate his vitals but I couldn't really find them and he said oh I'll take care of that. Like I said, he never did. He hadn't	A 489		

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A 489	Continued From page 10 entered a temp [temperature] on 257, urine output all day, and a good majority of the drain output on 259 by the end of the shift. I don't know if he writes them down in his notebook and at the end of the day enters them all or if he just has an amazing memory where he can remember 12 hours of output, I know I can't. At the end of the of the day he had numbers for them, [I] like to think that he's not just making the numbers up but I don't know." *On 7/25/23 at 11:35 a.m. RN F emailed RN A: "He pulled me aside this morning and thanked me for the feedback. Showed me his work list and that it was complete. It seems like what he said was taken to heart. I gave him a little pep talk on accepting for help/asking for it. I also told him I would look through his charting from last night and see if he missed anything." *On 7/25/23 RN A responded to the email communication above with: "Thank you so much for sending the specific concerns on [RN K's name], it is incredibly helpful in determining how to proceed. We will meet as a leadership team today and decide the next steps. *There was no documentation to support what was determined from that leadership meeting and what those next steps were. *RN K was terminated 39 days after the above email communication occurred for drug diversion. 7. Interview on 10/3/23 at 2:29 p.m. with RN G revealed he was a traveling nurse and had worked at the facility for a month and a half. During his onboarding orientation, upon hire, they had received training on drug diversion and abuse. To his knowledge, there had not been any further education or re-education on drug diversion since he was hired.	A 489		

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A 489	Continued From page 11 8. Review of the provider's 8/31/23 Diversion Question document revealed: *It supported: -There was an employee theft that involved PRN medications. -The medication diverted was vials of Fentanyl. *The automated dispensing system (ADS) worked as it should so no further updates or changes were needed. -There was no documentation to support how it was determined the ADS worked as it should have and no changes were needed. *The facility closely monitored the statistical dispensing rate of the nurses. -There was no documentation to support how that process had worked. *Staff were to have been educated about the need for appropriate handling of controlled substances. -There was no documentation to support when that education would happen or occurred and what departments should have received that education to ensure drug security throughout the entire facility had occurred. 9. Interview on 10/3/23 at 3:30 p.m. with pharmacy director B and controlled substance coordinator (CSC) C revealed: *The pharmacy director had been on leave when the drug diversion was confirmed. *The ADS contained a drug diversion software that was a double check system for the pharmacy department. *They received a daily dose reconciliation report specifically for controlled medications. *It was the responsibility of CSC C to review those reports. *CSC C: -Had identified the drug diversion that had	A 489		

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	430077	A. BUILDING _____ B. WING _____	C 10/04/2023

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A 489	Continued From page 12 occurred on 8/27/23 through that daily report. -Would have reviewed those reports daily, except on the weekends. Those reports would have been reviewed on Monday. -Had worked with the staff on the investigation of drug diversion that had involved RN K. *RN K: -Had flagged higher for the wasting of a controlled medication over that weekend. These would have been compared to the top twenty pulls of a controlled medication by other nursing staff. -Had sixteen pulls of Fentanyl vials with excessive wastes from those pulls. -Had an increase in wastes of a controlled medication approximately a week and a half prior to that weekend. But the pulling of that med was not excessive. *There had not been a review of the drug security system, policies, and procedures after the investigation to support the reason why no changes were required. *Pharmacy director B stated: -"There was no need to because the system worked as it should." -"He was caught and within six weeks of employment." -"To us that is a success story and being lower than the national average supports that." -"No one else had caught him and he had been diverting for a year." -"Education? What would we have educated the staff on?" -"The staff know better, they know not to do it." -"We have systems and processes in place and they worked." -"If there was re-education needed for the staff, that would be up to the nursing department, not us."	A 489		

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A 489	Continued From page 13 -"We did our part, we caught him and assisted with the investigation." -"I do education with the staff when they are first hired and no, not again." -"Because I tell them to just not do it, they know better, and because I will catch them if they do." -"No, nothing was changed, no education for staff. I find absolutely no value in that." -"Like I said, don't know what we would have educated the staff on." -"Everyone knows it's wrong, everyone is educated, so why would we put them through all that." 10. Review and interview of employee files for RN G and RN K with human resource representative H and education representative I revealed: *RN G: -Was a traveler and was contracted to work for them starting on 8/14/23. -Had received a condensed version of the onboarding orientation of the provider's policies and processes. -The goal was to get those travelers trained on the the floor working as soon as possible. -Was not included in the Teal Day orientation. *Teal Day orientation included training from pharmacy director B on the pharmacy processes and drug diversion. *RN K was hired full-time and had attended the Teal day orientation with the pharmacy department. *They were unsure why the traveling staff had not been included on Teal Day orientation. -Those staff would have reviewed the PowerPoint from the pharmacy department orientation process from the Teal Day presentation. -The PowerPoint that those traveling staff reviewed from the pharmacy department had not	A 489		

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A 489	Continued From page 14 included the in-person training from the pharmacy director on drug diversion. *They agreed drug diversion was an important training and should have been included in the orientation for the traveling nurses. Interview on 10/4/23 at 12:50 p.m. with pharmacy director B revealed he: *Confirmed: -The traveling staff were not required to be educated on drug diversion like the permanent staff. -He would have completed an in-person training on Teal Day on the processes of the pharmacy department and drug diversion. *Stated: -"I have nothing to do with educating the traveling staff." -"I can't tell you why, other then, their training is more condensed." -"I believe it was the nursing administrations decision that they didn't need any training from me." -"I can't tell you why it's different but that I do not want it that way." -"If I had it my way, their training from me would not be any different. It's a big piece for drug diversion training." -"I've asked for it to be changed, especially around COVID but it has never changed." *Further confirmed: -There was no further training from the pharmacy department, other than the annual iLearn requirements after orientation. -After a drug diversion confirmation he would not have done any re-education for the staff. -The education was up to the nursing department. *Agreed: -The pharmacy department was responsible for	A 489		

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A 489	Continued From page 15 the retrieval, administration, security, and disposal of all medications throughout the facility. -The ICU was not the only department in the facility that utilized the use of controlled substances. *He stated: "I see no value in re-educating the staff. They know it is wrong and should not do it. What would be the purpose." -"There was no need to review our system and processes for changes because we didn't need to. It worked!" -"Some staff will try again, but like I said, they will get caught." 11. Interview on 10/4/23 at 1:18 p.m. with RN A revealed: *She had not received any guidance or direction from the quality and risk team or pharmacy department on the following: -Any re-education requirements for her staff after the drug diversion for improvement and understanding of the processes. -What should have been monitored or audited on the staff to ensure: --They were knowledgeable and understood the policies and processes for medication administration, security, retrieval, and the waste for controlled medications. --The staff were adhered and followed those policies and procedures the provider had put in place to support medication security. *She was new to her role as a director and the drug diversion occurrence with RN K had been her first investigation of that type. *She stated: -"Yes the added guidance would have been helpful and appreciated I'm new to the director role and that was my very first drug diversion." -"All I was asked from leadership was if I had	A 489		

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A 489	Continued From page 16 completed my piece of the report yet. There was a timeframe for completion I guess. But there was nothing else after that." -"I want to make sure we are doing the right thing in my department." -"I don't know why the orientation is so different for the travelers than us. Only that they probably need them to get on the floor and working as soon as possible." -"I agree, the Teal Day education from the pharmacy department is important, esp the drug diversion." -"Even if the traveling staff don't receive that education, my expectations of their performance is no different then my permanent staff." 12. Interview on 10/4/23 at 2:01 p.m. with vice president of quality safety risk management J revealed: *She was aware of the drug diversion that involved RN K. *Nothing had escalated as an area of concern with their auditing or monitoring systems. *She stated: -"It was looked at as a success story for catching him." -"We are more of the facilitators with these investigations." -"The pharmacy director and his team, along with the directors gather the information and do the investigation." -"We just gather the information from them and are the ones who interact with the state department." -"If we thought further guidance was needed, by all means, we would do that." -"But truly, there was none that was needed here that we could see." *The education would have fallen back on the unit	A 489		

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directors.
*She stated:
-"It is not our philosophy to do a big bang on re-educating for this. We are to big for that."
-"There are other areas that deal with controlled substances just like ICU, but this diversion was focused to just that area."
*She was aware of the condensed version of orientation and training for the traveling staffing.
*She stated:
-"Drug diversion would be covered in the policies that they review."
-"They get a more condensed version of training because we need them on the floor. Some of it falls on the corporation we contract with."
-"I don't see a need for a change here."
-"The expectation on their performance is the same even though their training is condensed."
*She would have expected the pharmacy department to be involved with the investigation, review of policies, processes, and education for the staff.
*She was not aware that the pharmacy director had not felt obligated to be involved with any:
-Further education to the staff after a drug diversion to ensure they understood the policies and processes for the security of controlled substances.
-Review of their internal processes to ensure no changes were required after a drug diversion happened.
*She stated: "I can see both sides of the story."

13. Review of the provider's July 2022 Drug Free Workplace and Drug Diversion Guidelines policy revealed:
*"All parties connected with such investigations are expected to cooperate in resolving the issue."
*The policy failed to address:

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A 489	Continued From page 18 -The process for the staff to follow should a potential drug diversion concern was identified. -What departments or staff were expected to assist in resolving a drug diversion issue. -The follow-up process to support the results of the root cause analysis and how to determine if a process change should have been implemented or not after a drug diversion had occurred. Review of the provider's September 2021 Drug Security and Storage policy revealed: *"The pharmacy department is in charge of drug security and storage at Monument Health and monitors in accordance with Federal, State, and Institutional guidelines to prevent theft and/or unauthorized personnel from access drug storage areas." *The policy failed to support what the pharmacy involvement should have been for staff training or re-education after a breach in drug security was confirmed.	A 489		

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

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{A 000}	INITIAL COMMENTS An onsite revisit survey was conducted on 11/16/23 for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals for all previous deficiencies cited on 10/04/23. All deficiencies have been corrected and no new non-compliance was found. Monument Health Rapid City Hospital 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.