STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 57028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/25 through 8/7/25. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirements: F755, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/25 through 8/7/25. The area surveyed was resident elopement. Flandreau Santee Sioux Tribe Care Center had past non-compliance at F689.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (14) identified at risk for elopement, who had eloped (left the facility without staff knowledge). Failure of staff to ensure adequate supervision put him at risk for physical injury or serious harm. This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include:	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
AnnMarie Kutzke	Administrator	8/29/25

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F0689 SS = D	Continued from page 1 1. Review of the SD DOH FRI regarding resident 14 revealed: *On 7/9/25 at approximately 5:10 p.m., resident 14 had been seen on the unit by one nurse and two certified nursing assistants (CNAs). *At approximately 5:12 p.m., the front door wander guard alert system alarm sounded. *At 5:19 p.m., CNA F responded to the alarm at the front door, checked the front of the building and the front parking lot. Having not seen anyone, she returned to the facility, shut off the alarm, notified staff, and a facility search was initiated. *At 5:22 p.m., RN G began to search the surrounding area in her vehicle and located resident 14 at 5:36 p.m. walking down Jones Drive. -That was approximately two tenths of a mile from the facility. -He stated he was going to visit his sister, then accepted a ride back to the facility. *Director of nursing (DON) B was notified at 5:28 p.m. and notified administrator A at 5:32 p.m. *Tribal police were notified and responded to the facility as resident 14 returned to the facility. 2. Review of resident 14's electronic medical record (EMR) revealed: *He was admitted on 4/15/25. *His diagnoses included vascular dementia (a group of symptoms affecting memory, thinking, and social abilities), diffuse traumatic brain injury (a brain injury caused by an outside force), epilepsy (a neurological condition characterized by unprovoked sudden, brief disturbances in brain activity), and alcohol abuse. *His 4/15/25 Brief Interview for Mental Status (BIMS) assessment score was five, which indicated he had severe cognitive impairment. *His 4/15/25 elopement risk assessment indicated he was ambulatory, had a history of wandering, and had a high risk of wandering.	F0689	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Executive Director/Administrator or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of survey as condition of participate in Title 18 and Title 19 programs. This plan of correction is submitted as the facility's credible allegation of compliance.	

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F0689 SS = D	Continued from page 2 *A 4/17/25 care plan focus area identified his elopement risk. -A 4/23/25 care plan intervention for "WANDER ALERT: Staff to check [if his] wanderguard [Wanderguard, a wearable door alarming device] is functioning and working properly every night," had been updated on 7/15/25 with information identifying his Wanderguard number. *On 7/9/25, resident 14 had eloped, and the family and the physician had been notified. *On 7/9/25, Minimum Data Set (MDS) coordinator/registered nurse (RN) C, completed an assessment to verify there had been no injury, and neurological checks were completed as scheduled for 72 hours. *On 7/10/25, a medication review was completed with no changes recommended. *On 7/14/25, a care plan intervention had been added to "Notify [the] charge nurse if he is pacing up and down the hallways" to "identify pattern of wandering." 3. Interview and review of documentation on 8/7/25 at 8:48 a.m. with DON B revealed: *She had been notified on 7/9/25 that resident 14 had eloped, and he had returned safely to the facility within about 30 minutes. *Education on elopement and wandering had been completed with all staff. -This was verified with employee sign-in sheets. *Monitoring and audits had been conducted for all residents who were at risk for wandering to ensure their assessments and care plans accurately reflected their needs. *Resident 14 was ambulatory and liked to walk. Interventions have been implemented using restorative therapy to provide him with more supervised opportunities to walk outside. 4. The provider implemented systemic actions to ensure the deficient practice does not recur was confirmed on 8/7/25 by having:	F0689		

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F0689 SS = D	Continued from page 3 *Initiated and documented one-hour checks on six residents, including resident 14, "who wander or are at risk for wandering." *Reviewed all residents, identified those potentially at risk for elopement, and completed elopement risk assessments for those residents. *Provided education starting on 7/10/25, for all facility staff regarding resident wandering, elopement, policy revisions, and response to door alarm activations before their next worked shift. *Reviewed and updated care plan interventions for all residents at risk for elopement. *Reviewed and revised policies on elopement and wandering. *Initiated audits for new resident admissions for elopement risk to ensure appropriate interventions were implemented, and MDSs were completed to ensure care plans reflected the needs and concerns identified in the Care Area Assessments (care areas triggered for further evaluation based on MDS responses) (CAAs). *Initiated the above items into their Quality Assurance Program Improvement meeting on 7/31/25. Based on the above information, non-compliance at F689 occurred on 7/9/25, and based on the provider's 7/31/25 implemented corrective actions for the deficient practice confirmed on 8/7/25, the non-compliance is considered past non-compliance.	F0689		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,	F0755	Pharmacy Services/Drug Records/Labeling/Storage of Drugs and Biologicals Deficiency: Expired medications were found stored on medication carts and/or in medication rooms accessible to staff. 1. Corrective Action for Residents Found to Have Been Affected • All expired medications identified during the survey were immediately removed from use and properly disposed of per facility policy and state/federal regulations. • Medications were replaced as clinically indicated to ensure residents did not experience delay or interruption in treatment.	

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F0755 SS = D	Continued from page 4 and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure two of two medication carts had not contained expired medications that were available for administration to residents. Findings include: 1. Observation on 8/7/25 at 10:11 a.m. of the medication cart on the green wing revealed it contained: *Fifty tablets of Tylenol 325 milligrams (mg) that had expired in June 2025. *Twenty-five tablets of Carbidopa/Levodopa (medication to help treat Parkinson's disease symptoms) 25/100 mg that had expired in June 2025 *Twenty-nine tablets of Diphenhydramine (allergy medication) 25 mg that had expired in July 2025. 2. Observation and interview with registered nurse (RN) H immediately following the above observation of expired medications in the med carts revealed she: *Agreed that the above medications had expired. *Stated the night nursing staff should have been	F0755	2. Corrective Action for Residents Having the Potential to Be Affected • A facility-wide audit of all medication carts, medication storage rooms, emergency kits, and treatment carts was completed by August 16, 2025 to ensure no expired medications were present. • Any expired medications found were removed and disposed of immediately. 3. Systemic Changes to Prevent Recurrence • Licensed nurses and medication aides were re-educated by August 16, 2025 on the facility's Medication Storage and Disposal Policy, with emphasis on: o Checking expiration dates prior to medication administration. o Removing and disposing of expired medications per protocol. o Monthly inspection and cleaning of medication carts and storage areas. • The facility's contracted pharmacist will: o Review medication carts and storage areas monthly during routine inspections. o Document findings and report any deficiencies to the Director of Nursing (DON). • A new "Expired Medication Checklist" was implemented for weekly cart checks by charge nurses, to be submitted to the DON/designee.	

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F0755 SS = D	Continued from page 5 checking the medication carts for expired medication and removed for potential administration to residents. 3. Observation on 8/7/25 at 10:25 a.m. of the medication cart on the blue wing revealed twenty tablets of Gabapentin (medication to treat nerve pain) 600 mg had expired 8/2/25. 4. Interview and observation with certified medication aide (CMA) I immediately following the above observation of expired medication revealed: *She agreed that medication had expired. *The night nursing staff should have been checking the medication carts for expired medication and removed them from the medication cart. 5. Interview on 8/7/25 at 1:30 p.m. with director of nursing (DON) B regarding the observed expired medications revealed: *The night nursing staff should have been checking the medication carts for expired medication and removed them from the medication carts. *DON B did not have a night shift check list of tasks to complete that included checking the medication carts for expired medication. DON B was requested to provide a policy on expired medication. DON B stated the facility did not have a policy on expired medication.	F0755	4. Monitoring to Ensure Ongoing Compliance • DON/designee will conduct weekly audits for 8 weeks, then monthly ongoing, of all medication carts and storage rooms to verify no expired medications are present. • Audit results will be reviewed at the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months, then quarterly thereafter. • Any identified concerns will trigger immediate re-education and corrective action. 5. Completion Date • The facility will achieve full compliance by: September 12, 2025.	9/12/2025
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812		

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F0812 SS = E	Continued from page 6 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow food safety standards by not having monitored and documented food temperatures for 40 of 192 meals served to residents from 5/1/25 through 8/3/25. Findings include: 1. Observation and interview on 8/5/25 at 10:15 a.m. with cook E in the kitchen revealed: *A three-ring binder on top of the steam table labeled dinner temp book. *Cook E stated kitchen staff were to document food temperatures in the temp book. *He stated there was a temp book for breakfast, dinner, and supper. *He knew food had to be heated to certain temperatures. *He agreed there were some food temperatures that were not documented in the dinner temp book. Review of the breakfast, dinner, and supper food temperature books from 5/1/25 through 8/3/25 revealed 40 of 192 meals served to residents did not have documentation to support the temperatures of the foods served to the residents had been checked for safety before being served. Interview on 8/6/25 at 10:31 a.m. with certified dietary manager (CDM) D regarding food temperature checking and documentation revealed:	F0812	Observation showed missing temperatures in monitoring of food temperatures. No residents had a negative outcome. All residents have the potential to be affected by the deficient practice. The facility has developed and implemented and re-educated the dietitian, certified dietary manager, cooks, and dietary aides on the policy of monitoring of food temperatures. The certified dietary manager and/or designee will audit food temperature logs five (5) times per week for six (6) weeks to ensure the system is reimplemented. The facility will bring the results of the audit to QAPI for review and discussion. The facility will achieve full compliance by: September 12, 2025.	9/12/2025

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F0812 SS = E	Continued from page 7 *She was a contracted certified dietary manager. *She knew there were undocumented resident meal temperatures in the temp book. *The cooks were responsible for checking and documenting food temperatures of the residents' meals. *She stated that no food temperature documentation meant there was no proof food was heated to the proper temperature before being served to the residents. *She agreed food temperature documentation was not being completed for every meal and without that documentation, there was no way to prove foods were heated to the proper temperature before serving to the residents. Interview on 8/7/25 at 3:40 p.m. with administrator A regarding food temperature checking and documentation revealed: *She was a contracted interim administrator that started in June 2025. *Staff should have documented food temperatures for every meal to ensure food quality and safety standards were met. *She agreed that the dietary staff were not completing food temperature documentation for those resident meals. Review of the provider's 2/13/23 Food Preparation and Service policy revealed: *"Food and nutrition services employees [at] Flandreau Santee Sioux Tribe Care Center prepare and serve food in a manner that complies with safe food handling practices." *"6. The following internal cooking temperatures/times for specific foods are reached to kill or sufficiently inactivate pathogenic microorganisms: -145 degrees for 15 seconds. --Raw eggs cooked for immediate service. --Fish (except as listed below). --Meat (except as listed below).	F0812		

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F0812 SS = E	Continued from page 8 --Commercially raised game animals, rabbits. -155 degrees for 15 seconds. --Ground meat (beef, pork). --Ground fish. --Raw eggs held for service. --Comminuted meat, fish, or commercially raised game animals. --Injected or mechanically tenderized meat. --Ratites (ostrich, rhea and emu). -165 degrees for 15 seconds. --Wild game animals. --Poultry. --Stuffed fish, meat, pork, pasta, ratites, & poultry. --Stuffing containing fish, meat, ratites & poultry."	F0812		

South Dakota Department of Health

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	80038	A. BUILDING: _____ B. WING _____	08/07/2025

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S 000	Compliance/Noncompliance Statement Surveyor: 45383 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted on 8/5/25 through 8/7/25. Flandreau Santee Sioux Tribe Care Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement Surveyor: 45383 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 8/5/25 through 8/7/25. Flandreau Santee Sioux Tribe Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: AnnMarie Kutzke | TITLE: Administrator | (X6) DATE: 8/29/25