South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10566 S	A. BUILDING: _____ B. WING _____	C 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH SPEARFISH HOSPITAL	1440 N MAIN ST SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A complaint health survey for compliance with Article 44:74, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 10/24/23 through 10/26/23. Areas surveyed included accidents and quality of care and/or treatment. Monument Health Spearfish Hospital was found not in compliance with the following requirement: S115.	S 000		
S 115	44:75:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any patient by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 48 hours of the event any death resulting from other than natural causes originating on facility property such as accidents or suicide patient. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.	S 115	Spearfish Quality and Safety Manager reviewed Monument Health's "Reportable Cases" policy and revised the "Serious Adverse Events (SAE)" policy to include the event notification process to appropriate regulatory agencies. To ensure appropriate reporting, education was developed regarding reportable cases to emphasize incidents with injury and unexpected death along with the definitions of abuse and neglect. The Spearfish Quality and Safety Manager as well as the Spearfish Quality and Safety Performance Improvement Coordinator will review and be educated on Monument Health's "Reportable Cases" policy and "Serious Adverse Events" policy by November 30, 2023. Any of the previously mentioned caregivers on leave will be required to complete review of policy and process for reporting before returning for their first scheduled shift. Department manager will monitor completion and report to the President of Spearfish Hospital. Monitoring: To ensure appropriate reporting, any event with injury requiring physician treatment and unexpected deaths will be reviewed by the Manager of Spearfish Market Quality, Safety, and Risk Management.	11/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas [signature] TITLE: President, Spearfish Hospital (X6) DATE: 11-17-23

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S 115	Continued From page 1 Each facility shall report a missing patient to the department within 48 hours. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall also report to the department as soon as possible any fire with damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. Each facility shall notify the department of any anticipated closure or discontinuation of service at least 30 days in advance of the effective date. Each facility shall report to the department any unsafe water samples for pools or spas. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to report an unwitnessed fall that resulted in a subdural hematoma for one of two sampled patients (6) with falls. Findings include: 1. Review of the provider's Fall Event list revealed patient 6 had a fall on 9/7/23, and there was "No harm to Patient." Interview and review on 10/25/23 at 3:22 p.m. with Quality, Safety, and Risk Manager B of patient 6's electronic medical record and the fall	S 115	Monitoring will continue until compliance reaches 90% for 3 consecutive months. Results will be reported monthly to the President of Spearfish Hospital.	

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S 115	Continued From page 2 risk report investigation revealed: *The fall had occurred on 9/7/23 at 9:05 p.m.: -Staff had heard his chair alarm sounding and upon entering his room had found him lying on the floor to the left of his chair with his shoulders on the legs of the bedside table. -He was returned to bed with the assistance of two staff members, a gait belt, and walker. -He had no changes in mentation, post-fall vital signs were stable, and he denied pain in his extremities. -Four hours post-fall, mild bruising was noted on his right scapula and left shoulder. -His head computed tomography (CT scan) revealed a small subdural hematoma. -A repeat head CT was scheduled at 7:00 a.m. in the morning. --The CT report indicated no appreciative increase in the hematoma. *The fall had not been reported to the South Dakota Department of Health. -The fall had not been reported because of miscommunication. She had thought the incident had been reported by Quality Manager H at Monument Health Rapid City. Quality Manager H had thought Quality, Safety, and Risk Manager B had reported the incident. Therefore, reporting of the "incident had been missed." --Quality Manager H was training her on the reporting process. Review of the provider's September 2023 Reportable Cases Policy revealed: *"Hospital and/or Medical Staff are to report to public authorities (e.g., police, coroner, Department of Health, Centers for Medicare and Medicaid Services) those cases which are required by law." *Mandatory Report - State/Federal law requires the following be reported:	S 115		

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S 115	Continued From page 3 -"Any incident or event where there is reasonable suspicion of abuse or neglect of any hospital patient by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The report shall be made orally or in writing to the Department of Health and the local State's Attorney, the Department of Social Services or to a local law enforcement office. -An investigation will begin immediately and a written report will be submitted to the Department of Health within 5 working days after the event..." Review of the provider's May 2023 Serious Adverse Events policy revealed: *Under the guideline section a serious adverse event (SAE) was an unanticipated adverse event which would have included persistent or significant harm. *Serious adverse events reporting process included: -"The employee who discovers the SAE must immediately report the event to his/her Clinical Resource Nurse (CRN) and Department Director or designee during regular business hours. -During non-business hours (evenings, nights, weekends and holidays) the employee must notify their CRN and Hospital Coordinator who will notify the Administrator On Call, Nursing On Call, Department Director and Risk Management and or Associate General Council. The Administrative team will determine appropriate immediate actions." *The reporting process included: -Reporting the SAE as soon as possible after the event was discovered. -Should the employee question whether an event was an SAE, they should call their "Department Director, the Vice-President of Quality, Safety, and Risk Management, or Associate General Counsel for assistance and clarification."	S 115		

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S 115	Continued From page 4 -"Reporting: Administration and Medical Staff from involved area(s) will be informed of the Serious Adverse Event if they have not previously been notified. -"Event Reports: The Serious Adverse Event should also be reported in the appropriate patient event reporting system." *The policy did not address reporting serious adverse events to the South Dakota Department of Health, what events would have been reported, or the required reporting timeline.	S 115		

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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 10/24/23 through 10/26/23. Areas surveyed included accidents and quality of care and treatment. Monument Health Spearfish Hospital was found not in compliance with the following requirement: A395.	A 000		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of one sampled patient (1) who had died, had been re-assessed and provided nutrition during his hospitalization. Findings include: 1. Review of patient 1's electronic medical record revealed he had: *Fallen at home and was transferred by ambulance to the hospital emergency department. *A right hip fracture. *Been admitted on 8/21/23. *An open reduction and internal fixation surgery of his right hip fracture had been completed on 8/22/23. *Sustained a large skin tear to his right elbow which was repaired in surgery. *Diagnoses included: alcohol abuse, macular degeneration, hepatitis C, and hypertension. Review of patient 1's 8/21/23 history and physical	A 395	Spearfish Quality and Safety Manager, the Director of the Nursing Unit and the Unit Nurse Managers reviewed Monument Health's "Nutrition Screening & Nutrition Assessment" and "Interdisciplinary Assessment and Reassessment" policies. Education was developed to ensure appropriate assessment and documentation will be provided to all Spearfish Hospital In-Patient nurses. Review of policies and education will be completed by all Spearfish Market In-Patient Nurses by December 4, 2023. Any Spearfish In-Patient Nurses on leave will be required to complete review of policy and process for reporting before returning for their first scheduled shift. Nursing Department Director or designee will monitor completion and report to the President of Spearfish Hospital. Monitoring: To ensure appropriate assessment schedules and documentation, a weekly audit of 5 In-Patient charts will be audited by Nursing Department Director or designee for appropriateness of nutritional assessment and accuracy of nutritional documentation and workflow. Audits will continue until compliance reaches 90% for 3 consecutive months. Results will be reported	12/04/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas Ahmuf — TITLE: President, Spearfish Hospital — (X6) DATE: 11-17-23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 395	Continued From page 1 revealed he: *Was alert and oriented upon arrival to the emergency department. *Was pleasant and cooperative. *Reported he drank at least six or more beers each night. -In the past when he was hospitalized he was placed in the intensive care unit and did have significant hallucinations and alcohol withdrawal symptoms. -He had been sedated for those. Review of his physician progress notes from 8/21/23 through 8/27/23 included severe protein calorie malnutrition. *Documentation supporting the malnutrition included: -He was to have a protein calorie supplement post-operative. -His albumin (a type of protein that is found in your blood. It is produced by your liver and serves several important functions in the body. One of its main roles is to help maintain the right amount of water in your blood and tissues).was low at 3.0. *He had body wide muscle mass loss. -Most likely was secondary to his alcohol use. *Physician progress notes from 8/28/23 through 8/31/23 revealed: -"Currently too weak to eat, however restart calorie protein supplement when more awake." -"He has not had nutrition since 8/4. Would consider PPN [peripheral parenterall nutrition] versus tube feeds after 7 days." *Physician progress note on 9/1/23 revealed: -"Appreciate nutrition consult. Recommend Tube feeds as opposed to PPN to use the gut." -"Nutrition to put tube feed orders in." -"If patient pulls feeding tube, at that point would consider PPN."	A 395	monthly to the President of Spearfish Hospital & Manager of Spearfish Quality and Safety, who will then share the results with the Quality and Safety Committee.	

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A 395	Continued From page 2 His initial nursing nutrition screen was completed: *On 8/21/23 at 5:26 a.m. -The screening scores indicated he was not a nutritional risk. *He had no unplanned weight loss, no non-healing wounds, his oral health was good, he had no chewing or swallowing problems, and he had no issues in obtaining food. *No further nutrition screening had been completed. Review of patient 1's care plan initiated on 8/21/23 and classified as continuing care revealed: *A problem for potential for compromised skin integrity. *One of the goals was his nutritional status would improve. *Interventions included: -Monitor and assess patient for malnutrition. -Monitor patient's weight and dietary intake as ordered or per policy. -Determine patient's food preferences and provide high-protein, high-caloric foods as appropriate. -Assist patient with eating. -Allow adequate time for meals. -Encourage patient to take dietary supplement as ordered. -Collaborate with dietitian. -Include patient/family/caregiver in decisions related to nutrition. *This care plan area had been documented by nursing that he was progressing towards his goal during his entire hospitalization. Review of nursing progress notes received from 8/27/23 at 6:22 a.m. through 9/2/23 at 2:08 p.m.	A 395		

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A 395	Continued From page 3 did not contain any documentation in regard to patient 1's nutrition. Review of patient 1's diet orders and intake records from 8/21/23 thrugh 9/2/23 revealed: *No documentation he had received any protein calorie supplements. *Nothing by mouth (NPO) on 8/21/23. *Advance diet as tolerated on 8/22/23 after his hip surgery. *His intake record for 8/23/23 was requested but was not received. *He ate 20% of his breakfast, 30% of his lunch, and no amount recorded for his dinner on 8/24/23. *He refused any food on 8/25/23, 8/26/23, and his 8/27/23 for all his meals. *The dietitian had not been consulted until 9/1/23. *He was NPO starting on 8/27/23 at 6:00 p.m. *A naso-gastric feeding tube was inserted on 9/1/23. -On 9/2/23 he received Fiber Source HN formula 130 cubic centimeters (cc) at 6:00 a.m., 150 cc at 8:20 a.m., and 48 cc at 8:39 a.m. *He died on 9/2/23 at 11:20 a.m. Review of patient 1's 9/2/23 inpatient death summary revealed: *Causes of death were listed as alcohol withdrawal delirium due to his hip fracture. *Other significant conditions that contributed to his death were listed as severe malnutrition, elevated international normalized ratio (the time it takes blood to clot), severe alcohol use disorder, and possible Wernicke encephalopathy (type of brain injury caused by a lack of thiamine). *After the surgical repair of his right hip fracture he developed severe alcohol withdrawal symptoms.	A 395		

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A 395	Continued From page 4 -Those symptoms had been treated with Librium and Ativan [used to treat anxiety]. -His severe hospital delirium persisted. -He was treated with high dose thiamine for possible Wernicke's encephalopathy. *He had no nutrition for seven plus days. -A naso-gastric feeding tube was placed on 9/1/23 with initiation of slow tube feedings. *It was suspected he had terminal delirium secondary to complex hospital stay. Interview on 10/25/23 at 1:00 p.m. with registered nurse (RN) C revealed: *She had provided care to patient 1. *At the time she cared for him he was sedated due to his alcohol withdrawal symptoms. *He would not have been able to eat or drink anything due to his sedation. *She had not reassessed his nutritional needs when she had cared for him. Interview on 10/25/23 at 2:30 p.m. with RN A revealed: *She had cared for patient 1 on several shifts. *He was either too sedated to swallow or was agitated. *He had not been offered any food or fluids, including a protein supplement when she cared for him. *She had not reassessed his nutritional needs when she had cared for him. *Medical doctor (MD) E was aware he was not eating or drinking. Interview on 10/26/23 at 8:00 a.m. with MD E revealed: *She had been aware he had not been eating. *The 8/4/23 date in her notes was an error, it should have been 8/24/23.	A 395		

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A 395	Continued From page 5	A 395		

*Patient 1 was not safe to eat or drink during his alcohol withdrawal.
*She stated she was watching his intake for seven days after the last time he had eaten to address his nutrition.
*When she had ordered the nutritional consult the registered dietitian had recommended starting with tube feeding instead of total parentaral nutrition (TPN).
*She agreed with the:
-Surgical repair of his hip fracture.
-Wound to his right arm from his fall.
-Increased calorie needs during his alcohol withdrawal.
-Nutritional interventions should have been put in place earlier.

Interview on 10/26/23 at 9:30 a.m. with quality, safety, and risk manager B revealed:
*An initial nutrition assessment was completed upon admission.
*A follow-up assessment should be completed at least every seven days.
*She agreed patient 1's condition had changed during his hospitalization.
*Another nutritional screening should have been conducted.
*A new nutritional assessment should have been completed again based on the professional judgement of the nurse.

Review of the provider's revised November 2022 Nutrition Screening & Nutrition Assessment policy revealed:
*"A nutrition screen will be completed by the nursing staff on each patient within 24 hours of admission and documented on the nursing nutrition screen flowsheet in Epic [electronic medical record]."

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

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A 395	Continued From page 6 *"Those patients determined to be at nutritional risk based on screening results, consult order, or diet order will receive an initial nutrition assessment by the Registered Dietitian within 48 hours of the nutrition screening." *"Follow up and reassessment will be determined by the Registered Dietitian using professional judgment and nutrition risk indicators. Patients determined to be high risk will be reassessed every 3 days, moderate risk every 4 days and low risk every 7 days. A completed nutrition reassessment form will be placed in an interdisciplinary progress note in the patient's electronic health record by the Registered Dietitian."	A 395		

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{A 000}	INITIAL COMMENTS A revisit survey was conducted on 12/11/23 for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals for all previous deficiencies cited on 10/26/23. All deficiencies have been corrected and no new non-compliance was found. Monument Health Spearfish 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.

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MONUMENT HEALTH SPEARFISH HOSPITAL	1440 N MAIN ST SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Compliance/Noncompliance Statement A revisit licensure health survey was conducted on 12/11/23 for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, for all previous deficiencies cited on 10/26/23. All deficiencies have been corrected and no new noncompliance was found. Monument Health Spearfish Hospital was found in compliance with all regulations surveyed.	{S 000}		

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