STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430016	A. BUILDING _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALTH CENTER	1325 S CLIFF AVE SIOUX FALLS, SD 57117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 1/7/25 through 1/8/25. Areas reviewed were abuse, neglect, patient rights, admission, transfer, and discharge rights. Avera McKennan Hospital & University Health Center was found not in compliance with the following requirements: A115, A143, and A145.	A 000	A meeting was held on 1/8/25 with leadership and educators to review policies, staff education, and monitoring. Gaps between policy and staff knowledge were identified, leading to the creation of a remediation plan. The plan includes policy updates, staff education, and audits performed. A root cause analysis was conducted on 12/27/24 to identify areas of improvement. Refer to A143 and 145.	03/15/2025
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on record review, video event review, observation, interview, and policy review the provider failed to protect patients' rights when staff failed to: *Ensure two of two camera monitoring rooms had been paused for patients not requiring camera monitoring. *Ensure a placard (sign) was displayed in patients' rooms with cameras notifying of the camera monitoring per provider policy. *Assess and secure potential environmental safety hazards for one of one sampled patient (3) who attempted suicide on 12/22/24 and subsequently expired on 12/25/24. *Ensure close observation with 15-minute safety checks for one of one sampled patient (3) had been performed and documented in accordance with the provider's policy. Findings include: 1. Record review, video event review,	A 115		

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

[signature] | President + CEO | Feb 19, 2025

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 115	Continued From page 1 observations, interviews, and policy review throughout the survey process revealed: *Patients' privacy or notification of a camera monitoring was not provided for patients placed in camera monitored rooms per the provider's policy. -Observation and interviews with staff revealed cameras in the adult unit A were always left on and no signage was placed inside the room advising the room was being monitored. *The provider's safety risk assessment of the environment had not included an assessment of toiletry supplies. *Behavioral Health Technician (BHT) H had not performed documented 15-minute safety checks for patient 3 per the provider's policy. -Per camera recording review, patient 3 had not been visually checked with 15-minute safety checks by BHT H from 6:39 p.m. until 7:15 p.m. on 12/22/24. -BHT H documented he performed his 15-minute safety checks on patient 3 at 6:51 p.m. and again at 7:00 p.m. on 12/22/24.	A 115		
A 143	Refer to A143, finding 1 and A145, finding 1. PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure: *Camera monitoring had been paused in two of eight patient rooms (1399 and 1464) for patients who did not require camera monitoring. *A placard had been displayed in patients' rooms with cameras notifying the patients of monitoring	A 143		

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A 143	Continued From page 2 per the provider's policy. Findings include: 1. Observation and interview on 1/7/25 at 11 a.m. with vice president R and nurse manager I revealed: *Unit A had two camera monitoring rooms. *Unit B had four camera monitoring rooms. *Unit C had two camera monitoring rooms. *Cameras would not have recorded when turned off. *Cameras should have been turned off by default. *Physician orders had not been required for camera use. *Nurses had determined whether cameras were to be turned on or off. *On 12/22/24, the camera for room 1464 occupied by patient 3 in unit A had been turned on. *The camera for room 1464 was not supposed to be on during that time. Interview on 1/7/25 at 11:25 a.m. with lead behavioral health tech (BHT) K revealed: *He was the lead BHT for unit A. *Cameras should have been turned off generally. *Cameras had been used when patients were asleep and when on a 1:1 (one-to-one) observation status. *He did not know why the cameras had been turned on. Interview on 1/7/25 at 11:46 with registered nurse (RN) M revealed: *She had worked as a nurse in unit A. *Cameras in unit A had been monitored for patients with suicidal ideations, self-harm risks and dementia. *Cameras in unit A had been generally turned on.	A 143	The camera monitoring policy was updated on 1/15/25 to include the requirement of a provider order. The policy revision was reviewed by BH Leadership on 1/8/25 and will be presented to the BH Adult Hospitalist team on 3/5/25 as well as the BH Safety Committee on 3/11/25. 1. Process for activation: ***a. Obtain provider order as soon as possible "BH Camera Room Observation."*** b. Contact security to turn on camera. c. Document intervention "BH Camera Room Observation" twice daily. d. Place placard in patient room and educate patient on camera monitoring. The order will query link an intervention to the nurse's worklist, indicating the patient is being observed via camera. Patient room camera monitoring signs have been replaced on all units. Hospital admission consent forms are being updated by compliance to include verbiage that patient may be monitored at any time during their stay with an anticipated go live date of 3/7/25. Starting 1/20/25, all camera-equipped rooms in adult, child, and BH adolescent units will be checked daily. A designated staff member on each unit will ensure that cameras are used only when justified by policy, a provider's order has been obtained, and appropriate signage has been placed in the patient's room. The staff will also confirm that cameras are turned off for patients who do not require monitoring. Nursing will discuss the need for ongoing camera monitoring during interdisciplinary team meeting each day.	3/15/25

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A 143	Continued From page 3 *She did not know why the cameras had been turned on. Interview on 1/7/25 at 1:40 p.m. with BHT O confirmed: *She generally had worked in unit A. *Cameras had been used in unit A for patients on suicide watch and who had been at risk for falls. *Cameras had been on at all times. Interview on 1/7/25 at 2:19 p.m. with lead BHT P revealed: *He usually had worked in unit B. *Cameras had not been typically turned on. *Patients needed a medical reason to be placed in camera monitored rooms. *He had been unsure who decided if cameras were turned on or off. Interview on 1/7/25 at 4:10 p.m. with BHT B revealed: *She usually had worked in unit A. *Camera rooms had been used for violent patients and patients who had been at risk for falls. *Cameras had generally been turned on. Interview on 1/7/25 at 4:30 p.m. with RN C revealed: *She had been a nurse in unit A. *Camera use had been ordered and used differently between the hospital units. *She had heard that orders were needed to turn cameras on in other units. *Security had to be contacted to turn cameras on and off. *Sometimes cameras had been left on after they had been no longer needed.	A 143	**Education Provided:** Education was provided to all adult, child and adolescent unit staff regarding the camera monitoring policy and the requirement of signage placed in the patient room when in use. All staff have signed an attestation saying they received the education. On 1/20/25, leaders sent messages regarding the required education and signoff process. Any staff who were not scheduled during this time (PRN / vacation / leave) were contacted by their leader and provided this education via telephone then the attestation form was signed by their leader. All staff have signed off on that education (except those on FMLA – leaders will educate upon their return to work). Leaders will validate camera monitoring policy education was effective as part of their daily rounding and will poll staff regarding camera use rationale, policy, and procedure with a goal of validating all staff. If gaps are identified, remediation, including staff name and date, will be documented. Camera use audits will be conducted daily x 30 days until 100% compliant. Audits will then be conducted weekly x 60 days until 100% compliance is reached. Audits will then be conducted monthly x 3 months until 100 percent compliant. Camera monitoring audits will include date, cameras off or on, an order has been obtained, sign placed in room, and justification for camera use. If any gaps in process are identified, remediation will be completed with the employee's name and date provided. Continued concerns will be addressed in conjunction with Human Resources using the corrective action process. Data, including justification for camera use, the number of camera use days per unit and number of compliance concerns per unit, will be sent to the Accreditation Manager monthly. The data will be reported to the Quality Committee bimonthly	

			by BHS Leadership beginning 3/19/25. The Quality Committee will verify goals were reached and sustained for duration laid out above prior to determining if concluding monitoring/auditing process is appropriate. These minutes will then be reported to the Board of Directors. The Nurse Managers will report audit results to the Vice President during their 1:1 meeting which occur no less than twice per month.	

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A 143	Continued From page 4 Interview on 1/8/25 at 8:20 with RN D revealed: *She had been a nurse in unit A *Cameras in unit A rooms had been turned on for weeks to months at a time. *The camera had been turned on for room 1464 on 12/22/24. *Patient 3 had stayed in room 1464 on 12/22/24. *She was unsure why the camera had been turned on for this room. *Security had to be called to have cameras turned off. *No specific person had been assigned to contact security to turn off cameras. *There should have been a sign posted in rooms with cameras when they had been turned on. *She had thought an order was required to use a camera for patient monitoring. Interview on 1/8/25 at 8:57 a.m. with psychiatrist E revealed: *She had never ordered a camera to be on for monitoring. *She had thought it was up to the nurses to determine if camera monitoring was necessary. Observation and interview on 1/8/25 at 9:15 a.m. with nurse manager I at unit A revealed: *Room 1465 had the camera turned on and had been occupied by a patient. *Camera monitoring had not been needed for this patient. *There was no placard posted in room 1465 that indicated camera monitoring. *She had been unable to locate any placards for camera use in unit A. Observation and interview on 1/8/25 at 9:25 a.m. with nurse manager I at unit B revealed: *Room 1399 had the camera turned on.	A 143		

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A 143	Continued From page 5 *Room 1399 had a patient staying in it. *There was no placard posted in room 1399 that indicated camera monitoring. *There had not been any placards available for use in this unit. Interview with nurse manager I on 1/8/25 at 11:55 a.m. revealed: *Her expectation was that cameras should have been turned off generally. *Signage should have been posted in the rooms while monitoring had taken place. Interview with security officer J on 1/8/25 at 2:30 p.m. revealed: *Unit A likely had cameras on more than units B and C. *Staff had to call security to turn cameras on and off. *Cameras had been turned on for room 1464 on 12/22/24. *Patient 3 had been staying in room 1464 on 12/22/24. Review of the provider's 1/25 Video/Audio Surveillance policy revealed: *"Cameras may be used if it is determined that the patient residing in the camera room merits an additional monitoring tool." *"If it is determined by staff a camera is to be on, contact the on duty Security Officer to have it activated." *"An order is not necessary for camera use." *"The patient will be told verbally the camera is recording and a placard approved for this purpose must be placed in the patient's room advising that the room is being monitored. The placard will be displayed in the patient room." *"Once surveillance is no longer required, unit	A 143		

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A 143	Continued From page 6 staff will contact the on duty Security Officer to have the camera shut off, and the placard removed at that time." Review of the provider's placard for camera monitoring notification revealed "For your safety, your room is monitored by a security camera." Review of the provider's undated Rights and Responsibilities booklet revealed: *"7. Patient Needs: -Privacy: You have the right to every consideration of privacy. All parts of your medical care, examination and treatment will be conducted so as to protect your privacy."	A 143		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review, video event review, observation, interview, and policy review the provider failed to protect a patient from neglect by not providing the services necessary to avoid the physical harm of one of one sampled patient (3) who attempted suicide and subsequently expired, including not having: *Ensure close observation with 15-minute safety checks for one of one sampled patient (3) had been performed and documented in accordance with the provider's policy. *Include an evaluation of toiletry supplies in their safety risk assessment of the environment. *Assess and secure potential environmental safety hazards for one of one sampled patient (3)	A 145		

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A 145	Continued From page 7 that attempted suicide and subsequently expired. Findings include: 1. Review of patient 3's electronic medical record (EMR) revealed: *He had been voluntarily admitted on 12/15/24 for worsening psychosis with deterioration in functioning. *His 12/15/24 history and physical indicated he had denied any suicidal ideations or homicidal ideations. *He had been placed on the adult unit C. *His treatment plan had included 15-minute checks and suicide precautions. *On 12/21/24, he had been found in the day room with just his underwear on. *On 12/22/24 around 11:00 a.m. due to his increase in paranoia, confusion, anxiety, irritableness, and hostile statements, orders from psychiatrist E were to transfer him to adult unit A. *On 12/22/24 at 2:19 p.m. a progress note indicated psychiatrist E had documented patient 3: -"Can be intrusive with peers, poor boundaries. -Has hallucinations and has delusions. -Has no suicidal ideation and has no homicidal ideation." *His 12/22/24 behavioral care plan indicated he had transferred to adult unit A on 12/22/24 around 5:00 p.m. to a room equipped with camera monitoring due to it being close to the nurse's station. -He did not require a room with camera monitoring. *Behavioral Health Technician (BHT) H had documented his 15-minute patient safety checks for patient 3 as follows: -5:01 p.m. location was dining room (DR) behavior was calm.	A 145	After review of camera footage and comprehensive internal investigation including an interview with involved employee by Human Resources and BH leadership, it was determined that the staff failed to perform required close observation checks. As a result of the findings, appropriate corrective actions were taken. The individual responsible for these observation checks is no longer employed. On 12/23/24, high alert messages were sent to all staff instructing them to review the *Safety Precautions and Level System* policy and sign off prior to beginning their next shift. Audits of close observation safety checks via camera are to occur every day the leader reports to work. This began the second week in January as a weekly process and increased to a daily process the week of February 17th. The audit process will be guided by the daily Observsmart (patient safety check system data) report with a goal to audit all staff. In the event of an extended leader absence, the daily audits will be completed by the Director. These audits are documented on a spreadsheet and will include date, staff name, times of camera validation, direct observation of patient and documentation, as well as any action taken. Coaching will occur if gaps in process are identified, and leaders will repeat, within 30 days, an audit of staff who have been coached. Any staff who were coached for not directly observing a patient during a round of checks will be re-audited within 10 days. Leaders will address continued noncompliance using the Avera corrective action process.	3/15/25

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A 145	Continued From page 8 -5:15 p.m. location was DR, behavior was calm. -5:30 p.m. location was DR, behavior was calm. -5:44 p.m. location was day room (DYR), behavior was calm. -6:06 p.m. location was patient room (PR), behavior was calm. -6:20 p.m. location was DYR, behavior was calm. -6:28 p.m. location was DYR, behavior was calm. -6:38 p.m. location was DYR, behavior was calm. -6:51 p.m. location was DYR, behavior was calm. -7:00 p.m. location was DYR, behavior was calm. *A nurse's note written by registered nurse (RN) C on 12/22/24 at 9:02 p.m. indicated patient 3 had been found in his room unresponsive during BHT F's 15-minute safety checks for the patient at approximately 7:13 p.m. -No pulse had been identified; CPR had been initiated. -He had been rushed to the adjoining hospital's emergency department (ED). -RN C had been notified by security the patient had drank a deodorant bottle and forced it down his throat at approximately 6:43 p.m. -RN C notified the staff at the heart hospital of deodorant bottle in his throat. *Patient 3 expired on 12/25/24 related to a global anoxic injury (brain injury characterized by a widespread lack of oxygen to the brain). Review of video footage of the suicide attempt of patient 3 on 12/22/24 revealed at: *6:32 p.m., he entered his room and laid on the bed. *6:36 p.m., he got out of the bed, turned on the light and began to go through his personal belongings. *6:37 p.m., he had closed the door to his room and was carrying two bottles of unknown liquids	A 145	A closed-loop toiletry process for the Adult A unit, involving a check in and check out of toiletry items, was developed and implemented on 12/23/24 and strengthened on 1/8/25. Patients were allowed to have the items for 30 minutes and the staff who checked out the items were responsible for checking them in. The check out sheets were monitored by the Resource Nurse daily and turned into the Nurse Manager daily to review. A unit meeting was held for the Adult A staff on 1/9/25 to obtain staff feedback regarding the toiletry process. The staff suggested single use personal hygiene products which were successfully tried beginning 1/20/25, confirmed as a safer option, and approved for permanent use. Behavioral Health began utilizing single use items on the Adult, BH Adolescent units as well as Senior Program patients who are independent with their cares on 2/17/25. The items approved to remain in the patient room include a full-size hair pick and miniature toothbrush. These items have been included in the environmental risk assessment for Behavioral Health. Any other personal hygiene items, outside of single use products, have been added to the contraband list which is used to identify items patients cannot have. For the Child Program, due to dexterity concerns that make single use items difficult to open, patients may be allowed to keep toiletry bottles in their rooms. If patients use these products inappropriately, they will be moved to single use items.	

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A 145	Continued From page 9 and personal deodorant. -He drank one of those two bottles of unknown liquid. *6:38 p.m., he put his fingers down his throat and began to cough and gag. *6:39 p.m., he got out of bed and went to the sink. -BHT H entered patient 3's room to perform the 15-minute safety check. -BHT H had documented at 6:38 p.m. that patient 3 had been in the DYR and his behavior was calm. *6:40 p.m., he drank another bottle of an unknown substance and began to attempt to force a bottle down his throat and was unsuccessful. *6:42 p.m., he tried to force the same bottle down his throat a second time and was again unsuccessful. *6:43 p.m., he lubricated the bottle with an unknown substance from another bottle, laid back down on the bed and began to use his hands in a forceful manner to push the bottle down his throat. *6:44 p.m., his arms were extended out from his body. *6:46 p.m., he had used his hands to plug his nose. *6:48 p.m., he began to turn blue and ceased to move. *6:49 p.m., He exhibited agonal breathing (not getting enough oxygen and gasping for air). *6:51 p.m., BHT H had walked outside of his room with an iPad in his hand. -BHT H had not opened his door to perform a visual safety check of patient 3. -BHT H documented that at 6:51 p.m., patient 3 had been in the DYR, and his behavior was calm. *6:55 p.m., BHT H walked back up to the nurse's station and had gone into the DR.	A 145	Rooms are checked for contraband between 2-4 times per day. This is an assigned task in the staff workflow and is signed off when completed and logs are kept for manager to review. **Education Provided:** Leaders of the Adult units sent messages regarding the updated toiletry practice on Adult A during the week of 12/30/24. Attestation of this education, via staff signature, for the Adult A staff began on 1/8/25. Also beginning 1/8/25, all staff who floated to Adult A were educated at the beginning of their float shift regarding this unit specific toiletry check in and out process, by the Resource RN, utilizing printed education. As this process was specific to the Adult A unit, the education was provided in real time so staff could ask questions and have current knowledge of the process during their float shift. The education was kept with attestation sign off at the Resource RN desk on the Adult A unit. Education regarding the change to single use products on the Adult, BH Adolescent, and Senior units was provided at all BH unit meetings on 2/13/25. The minutes of those meetings are emailed to staff who were unable to attend. Attestation of the knowledge of the product change, the addition of personal hygiene items to the contraband list was obtained for anyone not in attendance at the unit meeting. All staff were notified via email of the hospital change to single use personal hygiene products, the items approved to remain in the patient room, and the need for increased diligence during room checks due to the addition of personal hygiene products to the contraband list. Close Observation check audits have always been a part of the Behavioral Health practice however have not been scheduled or formally documented prior to this incident.	

			It is the intent of the BH Leadership team to continue with regular audits as a best practice going forward. Close observation audits will continue daily for a minimum of 60 days and after 60 days, once100% compliance with direct observation of all patients has been achieved, may move to weekly audits as part of the permanent process change. Documentation of the close observation check audits will include employee name, date audited, times audited, reason for audit and action taken, if any. If any gaps in process are identified, remediation will be completed with the employee's name and date provided. Continued concerns will be addressed in conjunction with Human Resources using the corrective action process. The Nurse Managers will report audit results to the Vice President during their 1:1 meeting which occur no less than twice per month. Leader completion audits will be conducted by the Vice President weekly. If any gaps in process are identified, remediation will be completed with the employee's name and date provided. Continued concerns will be addressed in conjunction with Human Resources using the corrective action process. Leaders will validate the close observation education was effective as part of their daily rounding and will poll staff regarding close observation policy and process with a goal of validating all staff. Coaching will occur if gaps in process are identified and remediation will occur with date and staff name documented. The close observation completion data will be sent to the Accreditation Manager monthly. The data will include number of audits per unit and the number of concerns per unit, as well as levels of remediation (where applicable). The data will be reported out on Quality Committee bimonthly by BHS Leadership beginning 3/19/25. The Quality Committee will verify goals were reached and sustained for duration laid out above prior to determining if concluding monitoring/auditing process is appropriate. These minutes will then be reported to the Board of Directors	

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A 145	Continued From page 10 *6:59 p.m.; BHT H left the DR and walked to the DYR. *7:00 p.m., BHT H was at the nurse's station with the iPad, walked past patient 3's room and down through the DYR. -BHT H again had not opened patient 3's room door to perform a visual safety check. -BHT H documented that at 7:00 p.m., patient 3 had been in the DYR, and his behavior was calm. *7:02 p.m., BHT H was back at the nurse's station. *7:15 p.m., BHT F opened patient 3's room door. She: -Continued to knock on his door and appeared to not have gotten a response from him. -Visually checked on him by walking into his room and approaching his bed. -Walked back out to the nurse's station and approached BHT B. *At 7:16 p.m. BHT F and BHT B entered patient 3's room and they: -Assessed patient 3 and checked for signs of breathing. -Alerted nursing staff to activate the emergency response system (EMS). *At 7:16 p.m. BHT H began Cardiopulmonary Resuscitation (CPR) on patient 3. *At 7:17 p.m., patient 3 was transferred to a gurney (wheeled stretcher). *At 7:18 p.m., patient 3 was transferred from the adult unit A to the adjoining hospital's ED. Observation and interview on 1/7/25 at 11:10 a.m. on Adult Unit A with nurse manager I and Vice President (VP) R in the intake room revealed: *Toiletry products had been placed in yellow bins labeled with the patient's room number. *Toiletry items in the bins included:	A 145		

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A 145	Continued From page 11 -Shampoo -Conditioner -Toothbrush -Toothpaste -Lotion -Deodorant -Mouthwash -Chapstick -Combs/Brushes/Picks -Hygiene products from home *Nurse manager I and VP R confirmed this process was implemented after the event on 12/22/24 of patient 3's attempted suicide and subsequent death. *VP R confirmed an event like this had never happened there before and he had reached out to other facilities and had reviewed literature for best practices to implement. *Nurse manager I and VP R confirmed toiletry items had not been considered contraband prior to the above event but were now considered a form of contraband on adult unit A. *VP R confirmed they are "constantly" reviewing this new process and best practices to determine if that process needed to be implemented throughout the other inpatient units. -VP R confirmed the patients placed on adult unit A were at the highest risk for self-harm and aggressive behaviors. *Nurse manager I confirmed patients were to ask staff for their hygiene products and staff were to provide the patients with their items. The expectation was for patients to return all of their toiletry products to staff. *There had not been a formal check in or check out documentation process created. -Nurse manager I confirmed staff were expected to communicate with one another which patients had been given their toiletry items and when	A 145		

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A 145	Continued From page 12 those items were returned. -It was the expectation the staff member who gave out the toiletry items to patients would ensure the items had been returned. -She agreed a more formal check in and check out documentation process would hold staff accountable to ensure items were brought back timely and accounted for. Interview on 1/7/25 at 11:25 a.m. with lead behavioral health technician (BHT) K revealed: *Every four hours a new BHT was assigned to perform safety checks on patients with the use of an iPad program called ObserveSmart. *All patients were to wear a beacon (tracking device) either on their wrist or ankle for staff to perform their safety checks. *To complete a patient observation, staff must have been in range (distance set by administration) of the patient's beacon. *Staff had the option to complete a "forced" observation (patient not wearing a beacon or patient is out of range) to complete the safety checks. -He confirmed if staff had over 5% of forced checks, ObserveSmart would notify management. -He confirmed staff still needed to observe the patient. *The expectation for staff was to visually look at the patient by opening the door. *He confirmed toiletry items were to be checked out to patients and not kept in their rooms, but there had been no log to document who or what time a patient's toiletry items were checked in or returned. Observation and interview on 1/7/25 at 12:10 p.m. with BHT N revealed he:	A 145		

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A 145	Continued From page 13 *Had been assigned as the 4-hour safety check staff. *Used the iPad to perform the 15-minute safety checks. *Confirmed if the patient's door was closed, the expectation would have been to open the door and lay eyes on the patient. *If a green light appeared next to a patient's name on the iPad, that meant it had "paired" with a patient's beacon and did not mean staff did not have to check on the patient. -The expectation had always been to visualize the patient. Interview on 1/7/25 at 1:40 p.m. with BHT O revealed: *Staff use an iPad program to perform 8-minute and 15-minute safety checks. *She confirmed staff are to visualize the patient with every check. *She stated, "If the patient is sleeping, you must watch for respirations." *Staff should not use the forced entry to document safety checks. *She confirmed depending on the connectivity with the patients' beacons to the iPad, you could have more than one patient's green light on at a time to complete documentation on. -Confirmed staff still needed to visualize each patient. *She confirmed toiletry items needed to be checked out and checked back in by staff, but there had been no log created to ensure staff accountability of that process. Interview on 1/7/25 at 4:05 p.m. with BHT B revealed she: *Confirmed when performing safety checks, eyes are to be on the patient.	A 145		

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A 145	Continued From page 14 *Stated, "We watch for their chest to rise and fall, and also take note of their emotional state." *Had been educated on the expectation to open the patient's door to check on them. *Had been working the night of 12/22/24 on adult unit A. *Had been alerted by BHT F around 7:13 p.m. to go look at patient 3 due to concerns about the patient's condition. *Had gone into patient 3's room and he was blue and dusky in color and not responding. *Had yelled for the RN to call a code. Interview on 1/7/25 at 4:30 p.m. with RN C revealed she: *Had been assigned as the resource RN on adult unit A on 12/22/24. *Confirmed that at 7:13 p.m. she heard RN G yell to call a code for patient 3. *Ran into patient 3's room and began CPR. *Helped assist in the transfer of patient 3 to the heart hospital emergency department for continued care. *Called security to check the camera for patient 3's room *Was told by security it had appeared patient 3 had forced a lotion bottle down his throat at 6:43 p.m. *Was unsure if BHT H had performed patient 3's 15-min safety checks. *Expected BHT's to check patients every 15 minutes by: -Visually laying eyes on the patient. -Checking for respirations. Interview on 1/8/25 at 8:18 a.m. with RN D revealed: *On 12/22/25, she had worked from 7:00 a.m. to 7:00 p.m. on adult unit A.	A 145		

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A 145	Continued From page 15 *She had received the transfer report from the adult unit C nurse about patient 3. *Patient 3 had transferred over to adult unit A around 5:00 p.m. -She and BHT H were handing out patient dinner trays in the DR which had included patient 3. *At 7:00 p.m. she had given a handoff report to RN G. *She clocked out at 7:06 p.m. *At 7:23 p.m. she had received a call from RN G regarding patient 3's status. *She drove back to the hospital and replaced RN G at the adjoining hospital's ED. *She had been informed that they pulled a deodorant bottle out of patient 3's throat. *She remained with patient 3 until he transferred to the hospital's main hospital. *She confirmed that after the event, all patient toiletries had to be checked out. -Stated, "I do not feel this is going well, this has never happened before, we are taking away their dignity." -Confirmed a log would be helpful to know what's being checked out and by whom. *Confirmed the expectation for BHT's when performing the 15-minute safety checks would have been to visualize the patient. Interview on 1/8/25 at 8:55 a.m. with psychiatrist E revealed: *She had been treating patient 3's psychosis (mental disorder characterized by a disconnection from reality). *Patient 3 had been having episodes of impulsiveness and would have been a better fit in adult unit A. *Patient 3 had not expressed any suicidal ideations. *Patient 3 had orders for 15-minute safety	A 145		

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A 145	Continued From page 16 checks. *Her expectation would have been for staff to look at the patient when performing safety checks. *Confirmed patients were no longer allowed to keep their toiletry products. - She thought the process had been going "ok". Interview on 1/8/25 at 11:55 a.m. with nurse manager I revealed: *Her expectations regarding BHT's performing 15-minute safety checks were: -Staff were to always have eyes on patients. -BHT's were to be out in the DYR and not behind the nurse's station. -When performing the 15-minute safety checks, the BHT's sole responsibility would have been to check on patients. -BHTs had been trained to check for breathing and to visualize the patient's hands and head. Interview on 1/8/24 at 2:22 p.m. with security J revealed: *On 12/22/24, he came to work at 6:00 p.m. *Prior to the beginning of his shift, he had received a debrief of any events that had occurred that day. *At 7:15 p.m. he had responded to the medical emergency on adult unit A and assisted the nursing staff. *He had realized patient 3's room had a camera in it and placed a call to another security officer to pull up the camera footage. *He had verified from the camera footage that patient 3 had forced a bottle down his throat at 6:43 p.m. *He called up to the floor to notify the nursing staff of what he had visualized on the camera footage. *He stated, "I have never heard of something like	A 145		

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A 145	Continued From page 17 this before." Interview on 1/8/25 at 3:10 p.m. with RN G revealed: *On 12/22/24, her shift was from 7:00 p.m. to 7:00 a.m. *She had received a report from RN D. *She had been in the medication room when the BHT's called a code. *She had gone to patient 3's room and staff had been performing CPR. *She had gone with patient 3 to the hospital ED. *She confirmed all toiletry items needed to be checked out and checked back in. -She stated, "Whoever gives items out is responsible to ensure items come back." -She confirmed a log would be helpful. Interview on 1/8/24 at 3:30 p.m. with BHT F revealed: *On 12/22/24, her shift began at 3:00 p.m. on adult unit A. -From 3:00 p.m. to 7:00 p.m. she had been assigned to be on a 1:1 observation with a patient. *At 7:00 p.m. when she had received a report from BHT H, he had confirmed he would complete the 7:00 p.m. 15-minute safety checks for all patients on adult unit A. -At 7:00 p.m. BHT H documented the 15-minute safety check for patient 3. *At 7:13 p.m., she had started the 15-minute safety checks. -Patient 3 was the first patient she needed to check on. *At 7:15 p.m. she opened patient 3's room door and: -His face was blue. -His eyes were slightly open.	A 145		

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A 145	Continued From page 18 -She had called his name and continued to knock on door. -She went back out to the nurse's station to get another BHT to check on him. -BHT B visualized patient 3 and had yelled to call a code. *BHT F ran to get the gurney and crash cart. *She had stated, "The blue color of the patient is what alerted me. I did not see his chest rise." *She confirmed the expectation for 15-minute safety checks would have been to: -Open the patient's room door. -Put eyes on the patient. -Observe for respirations. -Observe for movement. Interview and review of the toiletries check in and check out process and education plan on 1/8/25 at 3:45 p.m. with vice president R, clinical educator S, and clinical manager I revealed: *"Toiletries for each patient will be checked out and checked in each time a patient is given their toiletry(ies). *Toiletries include hospital supplied items and/or patient personal products that are checked by intake staff prior to admission on the unit. *Patients will be given their supplies as requested. *Prior to a patient receiving their toiletry bin item(s), the staff member will check out each item for a maximum of 30 minutes and will document on the checkout sheet. *The staff member who checked out the item is responsible for ensuring the item(s) is checked back in within 30 minutes. *Patients are not allowed to check in or check out toiletries 30 minutes prior to the end of each shift. *Room checks will be done 4 times a day throughout the day."	A 145		

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A 145	Continued From page 19 *All staff assigned to unit A would be educated beginning at 4:00 p.m. on 1/8/25 and prior to the beginning of their shift. *Clinical manager I confirmed the resource RN will monitor the checkout sheet logbook to ensure compliance with the check out, check in process. Review of the provider's January 2025 Safety Precautions Level System policy revealed: *"Close Observation Check: -An in person visual observation of a patient at an ordered interval, actively observing behavior, mood, physical wellbeing (observing respiration), and environment. *All patients on suicide precautions are to be on 8-minute checks, 15-minute checks, line-of-sight, or 1:1. *15 Minute Observations. This level of observation may be implemented for any of the following reasons: -The patient is potentially suicidal, self-destructive, or present with moderate risk of self-harm. -The patient is a higher fall risk. -The patient is confused and/or risk for wandering. -The patient has the potential to be violent/aggressive to others. *The patient shall be observed by staff throughout the day and night every 15 minutes, with documentation of checks on the ObservSmart application." Review of the provider's January 2024 Safety Measures for the Adult Programs policy revealed: *"Patient observation checks are to be made regularly according to the appropriate close observation status. *A patient on suicide precautions will not have	A 145		

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A 145	Continued From page 20 access to shoelaces, strings, belts, sweatshirts with hoods, or other personal items posing a risk for self-harm. *Any object which patient may use to harm himself/herself or others will not be available to patient when he/she is not attended by staff." Review of the provider's November 2023 B.3 Contraband policy revealed: *Hospital provided toiletry products not listed as contraband items for adult unit A were: -Shampoo -Conditioner -Toothbrush -Toothpaste -Lotion -Deodorant -Mouthwash -Chapstick -Combs/Brushes/Picks Review of the provider's undated 2024 Suicide Screening Education revealed: *"Observer responsibilities: -Maintain constant observation of the patient -Document observations every 15 minutes on safety check flowsheet or Meditech intervention -Report changes in patient's condition or behaviors to Primary RN or Resource RN. -Be alert to contraband -Primary responsibility is to constantly watch/observe the patient. *Close Observation -Observer must complete an assessment of the patient's safety at minimum of every 15 minutes in addition to 8 minutes and line of sight checks. *15-minute safety checks include assessment of: -Environment -Patient's physical and emotional well-being	A 145		

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AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALTH CENTER	1325 S CLIFF AVE SIOUX FALLS, SD 57117

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A 145	Continued From page 21 -Patient's needs." Review of the provider's Patient's Rights and Responsibilities booklet revealed: *"7. Patient Needs: -Security: You have the right to have all care and treatments provided to you in a safe and secure area, free from neglect and abuse." Review of the provider's December 2024 Mental Health Environment checklist revealed: *No evaluation of toiletry supplies throughout the various environments. Review of provider's job description for a Behavioral Health Technician revealed: *"Implements suicide precautions as needed. *Assess changes in patient's condition/behavior and notified RN. *Maintains accurate and concise records, documenting promptly all pertinent information in the patient's EMR. *Comply with safety principles, laws, regulations, and standards associated with, but not limited to CMS, The Joint Commission, DHHS, and OSHA if applicable."	A 145		