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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/8/23 through 2/9/23. Areas surveyed included accidents, resident rights, and quality of resident care. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F580, F610, and F842.	F 000	Please accept the following as the facility's credible allegation of compliance (please note that this POC is submitted per state and federal requirements only. It should not be construed as the facility's admission of noncompliance with any standard, requirement, or regulation.) Submission of this Response and Plan of Correction (POC) 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 Administrator, or any employees,	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580	agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of the Plan of Correction do not constitute and should not be interpreted as 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 statement of deficiencies. Accordingly, the Facility has prepared and submitted this Plan of Correction for these deficiencies before 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 (IO) days of the survey as a condition to participating in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Without waving the preceding statement, the facility states that concerning: F580 Plan of correction F580 notify of changes (injury\decline\room, etc.) 1 - Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: The Resident is no longer a resident at the facility. He was deceased on 12-31-2022	03/09/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Christensen | TITLE: Chief Executive Officer | (X6) DATE: ~~03/02/2023~~ : 03/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on closed record review, interview, review of a South Dakota Department of Health (SD DOH) complaint intake, and policy review the provider failed to ensure the family and physician were notified of a change in condition for one of one sampled resident (1) on three separate occasions. Findings include: 1. Review of resident 1's medical record revealed: *He had been admitted on 6/15/17. *He had been transferred to the hospital on 12/24/22 with a diagnosis of pneumonia. *There was no physician or family notification regarding his change in condition on the following dates.	F 580	Plan of correction F580 (Continued) 2 - How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents who experience incidents or have room changes and residents with the decline of ADLs are identified to have the potential to be affected by the same alleged deficient practice. The director of nursing (DON)/designee will review the medical records of all residents with an accident involving the resident, which resulted in injury. These injuries have the potential to require provider intervention and include residents with a recent decline in ADL's to ensure the resident's provider, family, and/or POC or representative has been notified of any incident. These audits will occur weekly for six weeks on all residents with an accident. 3- The measures the facility will take or systems the facility will enforce will be altered to ensure that the alleged deficient problem will be corrected and will not reoccur are listed as follows: All staff nurses will be trained by the Quality Nurse by 3/9/2023 on the facility's notification of the change in condition policy, this stresses the requirement of prompt notification of the residence's representative of any changes in the resident's new condition and documentation of the notification in the progress notes. Training will be will include LPN E. Education and training will be required and provided by the Quality nurse for ALL licensed and unlicensed staff regarding their role in ensuring that when a resident event occurs, they are accurately reported, investigated, documented and necessary interventions are identified and implemented. Training will include LPN E.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 580	Continued From page 2 -11/11/22 his oxygen (O2) saturations were recorded at 62% and he was placed on O2 at 3 liters per minute per nasal cannula (N/C) --Normal O2 saturations are within the range of 90 to 100%. -11/25/22 he had crackles and rails in his lungs and had been drooling his food and a foamy white substance was coming from his mouth. -12/23/22 he had become non-responsive while in the shower room. -Licensed practical nurse (LPN) E was called to the room and observed his eyes were rolled back and he was unresponsive. --She performed a sternum rub; he then became responsive. Interview on 2/8/23 at 2:13 p.m. with LPN E regarding resident 1's family and physician notification of the incident above on 12/23/22 revealed she: *Had notified the physician. *Had attempted to call the daughter but she did not answer. *Then called the son and notified him. *Agreed there was no documentation to support the physician and family had been notified. *Knew it was her responsibility to notify the physician and family of the incident. *Thought she might have been in a "hurry and forgot to document the information." *Stated her normal process would have been to document in the progress notes "director of nursing, medical doctor and, the family notified [of the change in condition]." Interview on 2/8/23 at 3:15 p.m. with administrator A, chief operating officer (COO) B and interim director of nursing (IDON) D regarding physician and family notifications for	F 580	Plan of correction F580 (Continued) Education and training will be required and provided by the Quality nurse by 3/9/2023 for ALL licensed staff about the necessary documentation within the assessment skillset, an event occurrence report, and a South Dakota State reporting document. The purpose of documentation is to support the care administered and also to demonstrate compliance. LPN E will be included in the training. 4- Quality assurance plans are in place to monitor facility performance to ensure corrections are achieved and are a permanent practice in this facility as follows: A QA audit tool will be completed by the DON/ designee on all residents with a change in condition weekly for six weeks to ensure any change in a resident's condition has been communicated to the resident's provider and family promptly and is to be documented in the resident's progress notes. Ongoing compliance with this corrective action will be monitored via the facility QAPI program, with monthly meetings overseen by the Executive Director. The QAPI committee will determine any further audit requirement based on a threshold of 90% and above being met.	03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 580	Continued From page 3 resident 1 revealed: *Administrator A and IDON D both agreed the physician and family should have been notified of each change in the residents' condition listed above. *IDON D would have expected the nurse to provide notification to the physician and family. -When a change in condition occurred during the night, she would have expected the director of nursing to notify the family the next day if a nurse had not notified them. *IDON D would have expected the person who made the notification to document in the residents' progress notes. Review of provider's April 2022 Provider/Family Notifications policy revealed: *"Policy: To give prompt notification when a resident sustains a significant incident and/or change in condition. -Procedure: Licensed Nurse to: --1. Call directly to resident's provider, updating the situation of resident. Include: Vital signs and assessment needed. --2. Follow through with new orders and documentation of encounter. --3. Notify family as soon as patient is safe and/or stable."	F 580		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610	Plan of correction F610 Investigate/Prevent/Correct Alleged Violation 1 - Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: The resident is no longer a resident at the facility. He was deceased on 12-31-2022	03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 610	Continued From page 4 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on closed record review, interview, review of a South Dakota Department of Health (SD DOH) complaint intake, and policy review, the provider failed to ensure: *One of one registered nurse (RN) (F) had thoroughly and accurately completed an incident report for one of one sampled resident (1) after a fall with injury. *One of one sampled resident's (1) care plan had been reviewed and revised after a fall with injury. *One of one director of nursing (C) had thoroughly and accurately completed a Healthcare Online Self Reporting form for one of one sampled resident (1) after he had fallen. Findings include: 1. Review of resident 1's 12/2/22 incident report completed by registered nurse (RN) F revealed: *He had an unwitnessed fall at 5:05 a.m. -She heard "a loud bang" and found him lying on the floor beside his bed with certified nurse aides (CNAs) G and H standing next to him. *Incident Description: "A large hematoma was noted on the left side of his forehead and a skin tear noted to his right elbow." *Injuries Observed at Time of Incident: "No	F 610	Plan of correction F610 (Continued) 2 - How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents who experience incidents, have a fall, or are at risk for falls are identified to have the potential to be affected by the same alleged deficient practice. The director of nursing (DON)/designee will review the medical records of all residents with an accident involving the resident who has had a fall or is at risk for a fall to ensure all investigations are completed and will bring the results of each review to the weekly fall committee meeting for further review by the committee and by the administrator/designee. These audits will occur weekly for six weeks. 3- The measures the facility will take and/or the systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not reoccur: a) By 03/06/2023, The Quality Nurse will have updated the policy and procedure for falls that will include: fall prevention (with descriptions of duties for each department), identification of residents at risk for falls, fall investigation, fall reporting by DON or designee to SDDOH, huddle with staff post fall, immediate action after fall to prevent further potential harm to the resident while the investigation is in progress. Complete fall documentation will be documented in the patient chart by the Nurse on duty at the time of the fall, the completion of fall incident reports will be enforced, prompt notification of family / POC and the provider is imperative after a fall, care plans will be reviewed and updated as needed after all falls, and notice will be given to administration of investigation as included in the directed in-service March 9.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 610	Continued From page 5 injuries observed at time of incident." *CNAs G and H reported they had repositioned the resident on his side prior to the fall. *Predisposing Environmental Factors section of that report was checked "None." *Predisposing Physiological Factors section was checked "None." *Predisposing Situation Factors section was checked "None." 2. Telephone interview on 2/9/23 at 7:30 a.m. with RN F regarding resident 1 revealed: *He was unable to use his call light, mostly non-verbal, cognitively impaired, had significant physical limitations related to a history of a stroke that affected his right side and wore oxygen at night. *The cause of his 12/2/22 fall was due to "negligence" caused by CNAs G and H. -They improperly repositioned him on his side too close to the edge of his bed using two pillows approximately 30 minutes prior to the fall. --That positioning caused him to roll out of bed. *Those CNAs were no longer employed by the facility. *She agreed her incident report lacked specific detail regarding the resident's limitations, the suspected cause of his fall, or any interventions that had been immediately implemented to reduce his risk of another fall. Review of resident 1's care plan last revised on 5/25/22 revealed: *He was at risk for falls related to gait and balance problems and his use of an antidepressant medication. -An intervention initiated on 6/21/17: "Be sure [resident 1's] call light is within reach and encourage [resident 1] to use it for assistance as	F 610	Plan of correction F610 (Continued) b) An interdisciplinary "Falls Team" will be created by 03/06/2023 and will meet weekly to investigate all falls from the previous week, which will be reported to and signed off by the administrator/designee. The Falls team will include the DON /designee, the Quality Nurse, the CEO / designee, the COO/designee, and other interdisciplinary team members. c) Education will be provided to all staff on 3/7/2023 and 3/8/2023 to educate them on the new policy and procedures by Quality Nurse. All staff nurses will have been provided an in-service on the facility's notification of changes in condition policy and how to promptly notify the residents' representative of changes in the resident's new condition documenting the notification in the progress notes. RN F will be included. Education and training will be required and provided for ALL licensed and unlicensed staff regarding their role in ensuring that when resident events occur that they are accurately reported, investigated, and documented and necessary interventions are identified and implemented. RN F will be included. Education and training will be required and provided for ALL licensed staff about the required documentation within the assessment skillset of the staff member, an event occurrence report, and State reporting documentation. All staff will be trained that the purpose of documentation is to support care administration and demonstrate compliance. RN F will be included.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 610	Continued From page 6 needed. He needs prompt response to all requests for assistance." *He was at risk for skin breakdown and needed assistance with repositioning and bed mobility. -An intervention initiated on 6/21/17: "Reposition at least every 2 hours and as needed. Support with pillows." *He had a history of a stroke that affected his right side. -An intervention initiated on 6/21/17: "Turn and reposition q [every] 2 hours and PRN [as needed]. Keep body in good alignment. *He had self-care deficits related to his need for extensive assistance from two staff with most of his activities of daily living. -An intervention revised on 5/22/22: "He may use upper 1/4 side rails [on his bed] to assist him in mobility and repositioning." *The care plan had not been reviewed, no intervention revisions were made to the care areas above, and no new fall precaution interventions were added to the care plan after his 12/2/22 fall. Review of the Healthcare Online Self Reporting form related to resident 1's fall that was completed by DON C on 12/8/22 revealed: *His fall resulted in a "Lg [large] hematoma noted to lt [left] temple and skin tear to lt arm." -He had not required medical treatment outside of the facility for his injuries. *Conclusionary summary statement of facility investigation: -"...the nature of his injuries suggest that the resident had this fall during care" (provided by CNAs G and H). *Substantiation and Action: -"Was abuse/neglect allegation substantiated?" was documented "N/A" [not applicable].	F 610	Plan of correction F610 (Continued) 4- Quality assurance plans to monitor facility performance to ensure corrections are achieved and are permanent: All falls and incidents will be reported to QAPI monthly by DON /designee. The administrator/designee will review all fall investigations. The quality nurse will perform a weekly audit to ensure all investigations were completed and ensure signoff on audit by administration x6 weeks. DON/designee will perform weekly audits x6 weeks to ensure nursing staff fully and accurately complete fall incident reports and that the chart documentation is complete in the resident chart in case of any falls/incidents. Ongoing compliance with this corrective action will be monitored via the facility QAPI program, with monthly meetings overseen by the Executive Director. QAPI committee will determine any further requirement for audits based on a threshold of 90% being met.	03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 610	Continued From page 7 -"Why or why not?" was documented "unable to further interview traveler CNAs-thus unable to draw conclusion." *"Actions taken by the facility: [as a result of the fall investigation] (Check all that apply)": -Care plan review and revision had been checked. -Personnel education was not checked. -Leadership reviewed/revised was not checked. Interview on 2/8/23 at 2:15 p.m. with administrator A, chief operating officer (COO) B, and interim director of nursing (IDON) D regarding resident 1's 12/2/22 fall revealed: *Administrator A and COO B had been notified by DON C of the fall. -She was no longer employed by the facility but had been responsible for completing Healthcare Online Self Reporting forms and submitting them to the SD DOH at the time of the incident. *There was no check and balance system for either administrator A or COO B to review completed Healthcare Online Self Reporting forms and ensure: -Additional interdisciplinary team members knowledge related to the resident and input regarding the fall had been requested. -Appropriate post-fall interventions had been identified and implemented. *Administrator A "intervened" only if a report submitted to the SD DOH was rejected. -He "assumed" DON C "had done a good investigation" of the 12/2/22 fall to include appropriate fall prevention interventions had been in place and were followed. Continued interview and review of resident 1's care plan with administrator A, COO B, and IDON D revealed:	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 610	Continued From page 8 *It had not been reviewed and revised after his 12/2/22 fall to reflect: -His inability to activate the call light system. --Implementation of an alternative adaptive call light option. -Individualized repositioning instructions to decrease his risk for falls specifically when he laid on his left side in bed. -His physical inability to use a quarter-side rail. *Caregivers had not been re-educated on properly positioning resident 1 in bed to reduce his risk for future falls. Review of the revised April 2022 Post Falls Assessment and Follow Up Documentation policy revealed: "1. Note if falls preventions measures are care planned for, were they in use (ie mobility monitor, infrared bed alarm, etc)." Review of the undated Investigating Abuse, Neglect and Exploitation policy revealed it: *Described how to recognize and report signs and symptoms of abuse, neglect and/or exploitation. *The prompt and thorough investigation of those incidents by the charge nurse and/or the DON.	F 610		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842	Plan of correction F842 Resident Records - Identifiable Information 1 - Corrective actions which will be accomplished for those residents found to have been affected by the alleged efficient practice: The Resident is no longer a resident at the facility. He was deceased on 12-31-2022	03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 9 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	Plan of correction F842 (Continued) 2 - How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents who experience incidents resulting in the need for skin exams are identified as having the potential to be affected by the same alleged deficient practice. The director of nursing (DON)/designee will review all residents' medical records with an incident involving the need for skin assessment to ensure that the skin assessment was completed following accepted professional standards and practices; and that the facility has maintained medical records on each of these residents. These reviews will occur weekly for six weeks beginning March 9, 2023. Any issues identified will be further investigated by the DON/designee and promptly reported to Provider, responsible party, and facility Administrator, with staff education reviewed as indicated. Identified issues will be reported to State DOH, if indicated by the reporting guidelines, by the DON/designee 3- The measures the facility will take and/or the systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not reoccur: All staff nurses will be trained on the facility's procedure for skin assessments by the Quality nurse during an all-hands training by March 9 to ensure that all licensed nursing staff follow professional skin assessment documentation standards. LPN E will be included in this training 4- Quality assurance plans to monitor facility performance to ensure corrections are achieved and are permanent:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 10 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on closed record review, interview, review of a South Dakota Department of Health complaint intake, and policy review, the provider failed to ensure complete and accurate medical record documentation for one of one sampled resident (1). Findings include: 1. Review of resident 1's closed record revealed: *He had an unwitnessed fall on 12/2/22. *His post-fall skin assessments described: -On 12/2/22 a hematoma to the left side of his forehead and a skin tear on his right elbow from the fall. -On 12/7/22 a hematoma to the left side of his forehead, a scabbed left shoulder abrasion, a left side neck bruise, and a left eye bruise. -"No skin issues" on 12/14/22. -On 12/21/22 a hematoma to the left side of his forehead and bruising that was healing on the left side of his neck. *Neither of the assessments referred to above	F 842	Plan of correction F842 (continued) A QA audit tool will be completed by the DON/ designee on all residents with a skin condition weekly for eight weeks to ensure that the skin assessment documentation is accurate and meets professional standards. Ongoing compliance with this corrective action will be monitored via the facility QAPI program, with monthly meetings overseen by the Executive Director. The QAPI committee will determine any further audit requirement based on a threshold of 90% or above being met.	03/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 11 had comprehensively described the skin concerns that were identified and the documentation should have included the size, shape, color, progression in healing, and signs or symptoms of infection. 2. Interview on 2/8/23 at 1:00 p.m. with licensed practical nurse (LPN) E revealed: *Skin assessments included a head-to-toe visual inspection of a resident's body and a documented description of any identified skin concerns such as bruising, skin tears, and pressure ulcers. *She had completed the 12/14/22 skin assessment referred to above. -Resident 1 still had visible post-fall bruising she had not documented on that skin assessment. *Her failure to document accurate skin assessment findings for resident 1 "must have been an oversight." 3. Review of resident 1's care plan last revised on 5/25/22 revealed: *He was at risk for falls related to gait and balance problems as well as his use of an antidepressant medication. *The care plan had not been updated to reflect his 12/2/22 fall or any updated fall prevention interventions that had been implemented since that fall. 4. Interview on 2/8/23 at 2:15 p.m. with administrator A, chief operating officer (COO) B and interim director of nursing (IDON) D revealed: *Director of nursing C was no longer employed by the facility, but at the time of resident 1's 12/2/22 fall she would have been responsible for: -Ensuring LPN E had followed professional standards for skin assessment documentation	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 12	F 842		

that would have included factual content.
-Ensuring all licensed nursing staff had followed professional standards for skin assessment documentation that included comprehensive clinical descriptions of any skin concerns that had been identified during the assessment.
-Updating resident 1's care plan to include appropriate fall prevention interventions based upon findings from his fall investigation.
*IDON D confirmed "we have a documentation issue."

Review of the December 2002 Skin Assessment policy revealed:
*The focus of the skin examination included the resident's skin, hair, scalp, oral mucosa, and nails.
*The assessment was expected to include a description of the distribution and configuration of any skin concerns as well as the shape, border, texture, size, and surface of any skin concerns.

Review of the undated flowchart for incident reporting and investigation flowchart documentation revealed "Graph and measure all contusions, lacerations, blisters or wounds."

Review of the revised April 2022 Post Falls Assessment and Follow Up Documentation policy revealed: "1. Note if fall preventions measures are care planned for, were they in use (ie mobility monitor, infrared bed alarm, etc).

5. Review of resident 1's closed medical record revealed:
*He had been admitted on 6/15/17.
*He had been transferred to the hospital on 12/24/22 with a diagnosis of pneumonia.
*There was no physician or family notification for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 13 his change in condition on: *12/23/22 he had become non-responsive while in the shower room. -LPN E was called to the room and observed his eyes rolled back and he was unresponsive. --She performed a sternum rub; he then became responsive. Interview on 2/8/23 at 2:13 p.m. with LPN E regarding resident 1's family and physician notification of the incident from 12/23/22 revealed she: *Had notified the physician. *Had attempted to call the daughter but she did not answer. *Then called the son and notified him. *Agreed there was no documentation to support the physician and family had been notified. *Thought she might have been in a "hurry and forgot to document that information." *Stated her normal process would have been to document in the resident's progress notes "director of nursing, medical doctor, and family notified [of the change in condition]." Interview on 2/8/23 at 3:15 p.m. with administrator A, COO B and IDON D regarding physician and family notifications for resident 1 revealed IDON would have expected the person who made the notification to document that. Review of resident 1's care plan regarding falls revealed: *There had been a 5/25/22 focus that he was at risk for falls related to balance problems, he leaned too far forward in his wheelchair, and his use of a psychotropic medication (fluoxetine). *There was a 5/25/22 goal that his risk for falls would be minimalized.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 14 *The interventions for the focus and the goal had included: -To administer psychotropic medication and monitor for signs and symptoms such as dizziness, anxiety, drowsiness, insomnia, dry mouth, somnolence and notify his provider for possible decrease or discontinue the medication. -To ensure his call light was within reach and to encourage him to use it for assistance as needed. -Use of a Velcro positioning belt while in his wheelchair to maintain proper body alignment. -A need for a safe environment including: floors free from spills and/or clutter; adequate lighting, a working and reachable call light, the bed in low position at night, and personal items within reach. -Ensure he had well fitting shoes/slippers with non-skid soles when ambulating or mobilizing in his wheelchair. -Inquire and obtain orthotic shoes per recommendations. -Physical therapy to evaluate and treat as ordered or as needed. *There were no new interventions put in place to prevent additional falls after his incident on 12/2/22. *The last time the interventions were updated in his fall care plan was 7/22/20. Review of resident 1's pharmacy reviews from January 2022 through December 2022 revealed: *The pharmacist documented each month that resident 1: -Was a fall risk related to the side effects of his medication, fluoxetine. -His Morse fall scale, completed by the provider four times in 2022, indicated he was at low risk for falling, with one exception on 8/4/22 when his Morse fall scale (a method of assessing a persons likelihood of falling) indicated he was at	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435135	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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
F 842	Continued From page 15 moderate risk for falls.	F 842		