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
		A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An initial certification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/3/23 through 4/5/23. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirement: F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, closed record review, and policy review, the provider failed to: *Ensure, when made aware a resident (103) was going to a dental appointment that had not previously been disclosed to the facility, appropriate communication paperwork was sent to the dentist as well as subsequent notification to the physician about the resident's condition on return and the nurse's determination to hold a blood thinning medication, and accurate oral/dental assessment was documented for the admission assessment. *Ensure, when made aware a resident (104) planned not to return from a therapeutic leave, the resident had received any necessary discharge instructions and had appropriate disposition of medications documented. Findings include: 1. Observation and interview on 4/3/23 at 2:02	F 658	All residents have the potential to be affected. All follow up appointments for resident(103) were placed in the outside appointment book by Director of Nursing on 4/3/2023 to ensure knowledge and preparation is complete for all resident appointments. All current residents and families were contacted by LSW on 4/24/23 to ensure all appointments were in the book and families received education on the need for facility staff to book appointments. Admission packet was revised on 4/21/23 by LSW and Administrator to include education on facility personnel setting up medical appointments and transportation to ensure resident safety. LSW or designee will intake residents' appointments set prior to admission during the admission process. LSW or designee will audit new admissions to ensure resident and/or resident representative receives education on setting appointments and resident intake form is completed for 3 new admissions per week for 2 weeks, 2 new admissions per week for 2 weeks, and 1 new admission per week for 4 weeks. LSW or designee will bring results to QAPI to ensure substantial compliance. Physician notification education provided to all nursing staff by DON or designee on 4/24/23.	5/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty — TITLE: LNHA — (X6) DATE: 5/3/23

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.

RECEIVED MAY 03 2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 p.m. with resident 103 revealed: *One tooth was present in the middle of her bottom jaw, and no teeth were visible on the top jaw. *She reported her "gums are very sore from all my teeth getting pulled" and it was "still hard to eat." *Her visit to the dentist was "a couple of weeks ago." *She commented that "it bled a lot" and could not understand the reason "they did not stop her blood thinner" before they pulled her teeth. Review of resident 103's electronic medical record (EMR) revealed: *Her admission date was 2/21/23. *A care plan focus initiated on 3/2/23 of "potential oral/dental health problems r/t [related to] lack of natural teeth" had an intervention for staff to "set up oral care AM/HS [morning/hour of sleep]." *The Oral/Dental Status section for the admission Minimum Data Set (MDS) with an assessment reference date of 3/6/23 was: -Noted as "In progress" when viewed on 4/4/23 at 8:40 a.m. -Coded as "No" for each item, when viewed on 4/5/23 at 10:11 a.m., including "B. No natural teeth or tooth fragments" and "D. Obvious or likely cavity or broken natural teeth." Review of the progress notes on 3/24/23 in the resident 103's EMR revealed: *Licensed practical nurse (LPN) F documented: -At 2:30 p.m., resident 103 "left ceremony room during [name of a musical activity] and went back to her room with [name], CNA." -At 2:35 p.m., CNA "returns to the ceremony room and states that resident has a dental appointment but don't [does not] know who is	F 658	All licenses staff were educated by 4/24/23 by DON on the Transfer or Discharge policy and required paperwork. DON or designee will audit resident transfers to ensure proper physician notification and communication paperwork. DON or designee will complete audit for all transfers for 2 weeks, 2 transfers per week for 2 weeks, and 1 transfer per week for 4 weeks. DON or designee will bring results to QAPI to ensure substantial compliance. DON or designee will audit discharges to ensure proper discharge instructions and medication disposition. DON or designee will complete audit for all discharges for 2 weeks, 2 discharges per week for 2 weeks, and 1 discharge per week for 4 weeks. DON or designee will bring results to QAPI to ensure substantial compliance. Care Plans and MDSs were reviewed and updated by DON and LSW on 4/17/23 to include resident issues, potential discharge, and MDS completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2 taking her. Nurse went to appointment book and does not see an appointment booked." -At 2:40 p.m., LPN F "called over to the [name of clinic]/Dental and asked if resident had an appointment. [Name] (receptionist) states that yes she does it is at 3pm [p.m.] and [driver name] is going to come pick her up....[Driver name] arrived at facility at 2:55pm. -At 3:10 p.m., LPN F "also had over heard resident states that she isn't suppose to get any teeth pulled but wasn't sure what they were going to do. Staff unaware of resident's appointment until resident was asking who was picking her up." *At 5:00 p.m. and 5:01 p.m., LPN F noted resident 103 returned from the clinic at 4:55 p.m., and: -Resident 103 "had gauze in mouth and was hard to understand when talking." -Resident 103 "handed nurse the phone to talk to daughter and daughter asked if she still wanted to go out to eat since she had teeth pulled. resident wrote down on note pad 'i want to see her' daughter states that they will pick her up at 6:15 [p.m.] to go to [name]." -LPN F "tried to ask how many teeth she got pulled. was unable to understand put [but] sounded like four." -There was a "visible small amount of blood on gauze, no excessive bleeding." -Supplies from the dental clinic included, "4 packages of 2x2 [two by two] gauze a instant ice pack a new denture tooth brush and a [clinic name] post op instructions oral surgery that states, bleeding-keep gauze in place maintain constant firm pressure for 30-60 mins [minutes], if bleeding persiste [persists] or reoccurs replace gauze and maintain another 30-60 mins of constant pressure. can apply ice pack for 20 mins	F 658		

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
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3 if needed." *At 6:36 p.m., LPN F noted that [name] CNA reported she had changed the gauze in resident 103's mouth before she left at 6:15 p.m. *At 8:03 p.m., LPN G noted "held eliquis [Eliquis - blood thinner medication] as resident is having a difficult time with controlling bleeding in mouth." *At 8:32 p.m., LPN G noted, resident 103 "came back from outing in wheelchair assisted by son with blood running down her shirt with numerous paper towels held at her mouth. Resident stated 'I am bleeding all over' Nurse placed gloves on and took paper towels from resident, blood tinged saliva with a clot was located on towel. Nurse told resident that 'the gauze needs to stay in place and she needs to take it easy the rest of the night due to the recent pulling of teeth' Resident then got new gauze placed and washed up for bed. Resident took norco [hydrocodone-acetaminophen] PRN [as needed] due to pain and nurse held eliquis [Eliquis] due to the bleeding in the mouth." *At 11:06 p.m., LPN G noted resident 103 was "reeducated on being active and bending over in wheelchair that it is a risk for increase [increased] bleeding" and "also educated on spitting...nor drinking from a straw." LPN G also noted the "gauze output has been saturated in blood" *At 11:45 p.m., LPN G noted, "Vitals obtained on resident due to increased clotting time. temperature slightly elevated. resident is 10/10 pain currently." Resident 103 "nodded 'yes'" to authorize LPN G calling her "daughter and the hospital to discuss the issues we are having getting extraction sites to stop bleeding." Further review of the progress notes on 3/25/23 in the resident 103's EMR revealed: *At 00:15 a.m., LPN G called "[name] hospital	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 and...gave [name] the information on resident that extraction sites continue to bleed with no change. Ice packs applied, gauze filling mouth due to so many extraction sites. Increased risk for choking due to so much gauze. Resident frequently swallowing due to blood running to the back of throat." *At 00:36 am., LPN G received instructions from the hospital for using "Afrin [nasal spray] on the "extraction site then apply vaseline [Vaseline - petroleum jelly]," and "if facility didn't have that then if it continues to actively bleed she should probably be seen in the ER [emergency room]." *At 00:50 a.m., LPN G notified director of nursing (DON) B "of resident being sent to ER via car transport with daughter [name]." *At 8:56 a.m., registered nurse (RN) H called the [name] hospital and obtained an update, "Resident was kept through the night for observation, but will return later this morning. Bleeding has stopped in gums." *At 3:09 p.m., RN H noted resident 103 returned with a "new order for Viscous Lidocaine 7.5ml [milliliters] swish and spit QID [fours times a day] PRN for four days for oral pain due to tooth extraction, and Oxycodone 5mg [milligrams] PO [by mouth] q [every] 6 hours PRN for pain of 7/10 [rating for severity of pain, with ten as the maximum severity]." *At 3:43 p.m., RN H noted resident 103 reported "the dentist office called her and said she was due for a cleaning and appointment was scheduled for March 24th. During her dental visit she was informed of the need for tooth extractions." Interview on 4/4/23 at 8:45 a.m. with DON B revealed she was responsible for completing the MDS assessments, had not yet completed the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 5 MDS training, and did not realize that some sections of resident 103's MDS were not yet completed. Interview on 4/4/23 at 9:06 a.m. with licensed social worker (LSW) C revealed: *Resident 103 was at a different nursing home for two months after she had fallen at home and before her admission on 2/21/23. Her primary physician at that nursing home was not the same physician she had now. *Resident 103's dental appointment was made sometime before her admission and it had not been communicated to them. *The dental clinic called resident 103 and she understood her appointment was "just for cleaning." *Resident 103 "reported that they did not ask about her medications. She was not aware of the risk" of having her teeth pulled while taking blood thinner medications. *A medication list was not sent with resident 103 to the dental clinic. *Administrator (ADM) A, DON B, and LSW C "investigated the incident" and "presented [the findings] to the executive council at the tribe," and there was now improved communication about appointments from the dental clinic's healthcare facility. *Resident 103 would now "have family or staff go with her to appointments as her advocate." *LSW C did not know if resident 103's need for medical treatment after her dental appointment was reported to the South Dakota Department of Health (SD DOH). Interview on 4/4/23 at 9:44 a.m. with ADM A revealed: *The needed ER intervention that resulted from resident 103's dental procedure was not reported	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 6 to the SD DOH. *She did not "think it needed to be" since that incident "did not seem to fit any of the [application name] reporting categories." *The nurse on 3/24/23 did not "send a medication list because it all happened so fast." *The nurse received "some verbal education...that a medication list always needs to be sent." Interview on 4/5/23 at 8:43 a.m. with DON B revealed: *Resident 103's primary physician, at the healthcare facility where the dental clinic was located, was sent a fax sometime over the weekend to inform her of the excessive bleeding. *Her physician would not have responded right away. "No one is on call" at that healthcare facility, including the dentist. *The hospital that resident 103 was sent to was the provider's back-up healthcare facility. *There was no physician's order to hold the blood thinner medication prior to LPN G holding it on 3/24/23 at 8:03 p.m. "It was a clinical decision on the part of the nurse." Interview on 4/5/23 at 10:44 a.m. with DON B revealed: *"There probably should have been a Yes" on the Dental section, item B. No natural teeth or tooth fragment(s). *Had not completed an oral exam as instructed on Page L-2 under Steps for Assessment, bullet 4, in the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Review of the provider's investigation of resident 103's dental incident revealed: *Her physician was not notified until 3/25/23.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 7 *The dental clinic receptionist, interviewed on 3/27/23, reported she was not the "normal dental receptionist" but confirmed the scheduled dental appointment had been for resident 103's teeth to be removed. *LPN F reported that when she called the dental clinic before resident 103 left, the receptionist "just said she had apt [appointment] @ [at] 3 [3:00 p.m.]." *LPN F also reported she "didn't think about a med list being sent bc [because] facility should have been aware of procedures. Assumed cleaning." *Resident 103 reported she "wasn't [was not] sure if they were going to do [tooth extractions]." She stated, "when she got there they told her. Thought they were going to do a cleaning. Didn't [did not] ask about meds [medications]. Didn't ask if she was on blood thinners," and the [dental clinic] "called day before to confirm appointment." *Resident 103's "granddaughter stated this appointment was cancelled [sic] back when resident fell." *"Residents [resident's] calendar hanging in room has nothing about dentist written on 3/24. Where 'March' is located on her calendar right next to it, it has written Dentist 2:45." Review of the provider's Unusual Occurrence Reporting policy, issued 11/2/22, revealed: *Events to be reported: -"Via telephone to appropriate agencies...within twenty-four (24) hours" -"Written report...delivered to the state agency...within forty-eight (48) hours," included: --"Allegations of abuse, neglect...;" and --"Other occurrences that interfere with facility operations and affect the welfare, safety, or health or residents."	F 658		

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
	0134	A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8 2. Review of resident 104's closed record revealed: *She had been admitted 2/13/23 and discharged on 3/13/23. *She had been on therapeutic leave on 3/11/23. *She had spoken to licensed social worker C on 3/13/23 and expressed that she had not wanted to return to the facility. *A physician's order had been obtained on 3/13/23 by resident 104's physician to discharge the resident to home with her home medications. *Resident 104's medication had been sent to her medical clinic for pick up. Interview on 4/5/23 at 10:35 a.m. with director of nursing B regarding discharge instructions and accurate accounting of the medication for resident 104 revealed: *They had not provided any discharge instructions to the resident. *They had sent the medication to her medical clinic for the resident to have picked up. *They had not had an accurate accounting of the medication sent over to the clinic. Review of provider's 12/22 Transfer and Discharge policy revealed: *"When a resident is discharged from the facility, the following information will be documented in the medical record: -The date and time of the discharge. -The new location of the resident. -A summary of the resident's overall medical, physical, and mental conditions. -Disposition of personal effects. -Disposition of medication.	F 658		

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
		A. BUILDING _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An initial certification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 4/3/23 through 4/5/23. Flandreau Santee Sioux Tribe Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 5/3/23

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.

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
		A. BUILDING **01 - FLANDREAU SANTEE SIOUX TRIBE CARE CENTER** B. WING _____	**04/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An initial certification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/4/23. Flandreau Santee Sioux Tribe Care Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K342 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 342 SS=E	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200 feet travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure fire alarm system manual alarm boxes were installed as required at every nurse station. Findings include:	K 342	Additional pull stations were installed in each nurses station, front lobby, and back corridor on 4/14/23 by Electric Supply Co. All residents have the potential to be affected. The Maintenance Director will bring results to QAPI committee to ensure effectiveness of pull station locations.	4/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 4/24/23

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.

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
	0134	A. BUILDING **01 - FLANDREAU SANTEE SIOUX TRIBE CARE CENTER** B. WING _____	**04/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 342	Continued From page 1 1. Observation and interview with the director of maintenance and the administrator beginning on 4/4/23 at 11:16 a.m. revealed the only manual alarm box in the building was outside the mechanical/boiler room near the south entrance/exit. Interview at that same time confirmed that finding. They further stated that manual alarm box was in fact the only the only manual alarm box in the building. They then added there were no manual alarm boxes at any other exit or at any of the three nurse stations. Failure to install a fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100 percent of the building occupants. Ref: 2012 NFPA 101 Section 18.3.4.2.1, 18.3.4.2.2, 9.6.2.5	K 342		

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
	80038	A. BUILDING: _____ B. WING _____	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/3/23 through 4/5/23. Flandreau Santee Sioux Tribe Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty

TITLE: LNHA

(X6) DATE: 5/4/23