STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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
C 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.608 - 485.645 requirements for Critical Access Hospitals (CAH) and Long-Term Care Services ("swing beds"), was conducted from 8/15/23 through 8/16/2323. Avera Hand County Memorial Hospital and Clinic - CAH was found not in compliance with the following requirement: C- 922.	C 000		
C 922	DRUGS AND BIOLOGICALS ARE APPROPRIATELY STORE CFR(s): 485.623(b)(3) (3) Drugs and biologicals are appropriately stored; This STANDARD is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure one of one contrast dye warmer was maintained at a safe temperature for patient use. Findings include: Observation on 8/15/23 at 10:00 a.m. in the Computerized Tomography (CT) scan room revealed: *There was a warmed cabinet on top of the counter that contained two bottles of contrast dye used for patient imaging. *The thermometer had registered a temperature of 101.6 degrees Fahrenheit (F). Interview during the above observation with radiology technician (RT) B revealed: *The highest temperature that she had recorded in the warmer was 102 degrees F. *She was unsure of the safe warming range for the contrast dye.	C 922	**C 922** As it is not a required practice to have a contrast dye warmer, Avera Hand County will discontinue the use of its Dye Warmer in favor of storing contrast dye at room temperature of 68 - 77 degrees. Room temperature in the CT room will be monitored and documented by radiology staff on a daily basis. Radiology staff will keep two bottles of contrast in a locked cabinet in the workroom at all times and will monitor that temperature daily. Because the CT Scanner has the ability to warm the dye upon use up to 98 degrees Fahrenheit, this will suffice for proper patient care. Avera Hand County will update its "IV and Oral Contrast Storage" policy for CT Dye Contrast use to reflect the change in storage to room temps as well as how the dye will be warmed for use with patients. This Plan of Correction change will go into effect by 9/30/2023.	9/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew Campion
TITLE: Administrator
(X6) DATE: 8/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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
C 922	Continued From page 1 Interview on 8/16/23 at 9:00 a.m. with RT D and RT C regarding the contrast dye warmer temperature monitoring revealed: *They both thought that 102 degrees F was a safe temperature to warm the contrast dye to. *The highest temperature recorded for the warmer was 104 degrees F. *The injector arm on the CT machine had a warming ability to 98 degrees F. *They both stated that it took less than ten minutes to remove the contrast dye from the warmer for injection into the patient. *They had not rechecked the temperature prior to injecting the contrast dye into the patient. *RT C and RT D both stated they had reviewed the manufacture's product insert and were unable to find a recommended warming temperature for the contrast dye. Interview on 8/16/23 at 9:45 a.m. with administrator A regarding the warmer for contrast dye in the CT room revealed: *He had observed the contrast dye warmer in the CT room and stated that the warmer had no dial to regulate the temperature. *The administrator A agreed that following the manufacturers recommendation would have been the best practice for patient safety. Review of the February 2022 manufacturers product insert revealed: *Contrast dye was to be stored at 68-77 degrees F. Review of the provider's EmPowerCTA Injection System User's Guide revealed: *"Warmer: A device that attached to the contrast dye syringe to maintain the pre-warmed contrast	C 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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
C 922	Continued From page 2 at a steady temperature state of approximately 98 degrees F." Review of the provider's January 2023 IV (intravenous) and Oral Contrast Storage revealed: *"Iodinated contrast will be stored in a locked room in the main Imaging department and in CT." *"General storage temperature range is 68-77 degrees F." *"Two bottles of 100 milliliters iodinated contrast should be stored in the contrast warmer at all times." *"Iodinated contrast may be kept in the contrast warmer for one month." *"Contrast warmer will be documented on at least weekly. 95.9-101.3 degrees F is considered optimal with some variance in temperature."	C 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING _____ B. WING _____	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 A recertification survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted from 8/15/23 through 8/16/23. Avera Hand County Memorial Hospital and Clinic - CAH was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew Campion
TITLE: Administrator
(X6) DATE: 8/31/2023

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
	431337	A. BUILDING 02 - HIGHMORE BUILDING B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 A recertification survey for compliance with the life safety code (LSC) (2012 Existing Business Occupancy) was conducted on 8/15/23. Avera Hand County Memorial Hospital and Clinic (building 02) was found in compliance with 42 CFR Part 485.623(d)(1), requirements for critical access hospitals.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Matthew Campion

TITLE
Administrator

(X6) DATE
9/13/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/15/23. Avera Hand County Memorial Hospital and Clinic (main building-building 03) was found not in compliance with 42 CFR 485.623 (d)(1) requirements for critical access hospitals. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of deficiencies identified at K200, K353, K712, and K919 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	**K 200** Avera Hand County Memorial Hospital (AHCMH) will test the functionality of the magnetically locked doors via the Facility Lockdown system on 9/14/2023 to test whether or not they are tied to the automatic sprinkler system and are working as delayed egress magnetic locks. The testing will be conducted and overseen by the Dir. of Environmental Services/Maintenance. The current system when only in lockdown operates on a 30 second egress. This will be completed by September 30th, 2023.	9/30/2023
K 200	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the provider failed to provide egress doors as required at four of four cross-corridor exit door locations in building 3. Findings include: 1. Observation beginning at 9:45 a.m. on 8/15/23	K 200	AHCMH will also place the required signage as required by NFPA 101 Section 7.2.1.6 at the required door locations by September 30th, 2023. Documentation of installation adherence to the Life Safety Code will be completed upon the testing of the Lockdown system coinciding with the testing of the Automatic Sprinkler system. A policy will be developed by the Administrator and Dir. of Maintenance/EVS to address the specifics of how each system works individually and what process must be followed in the event that both are activated at the same time. As part of the Lockdown policy, it will be implemented that yearly, AHCMH will test the lockdown system in conjunction with the sprinkler system to ensure the egress door system is working as it is designed to work. This policy will be created and implemented by September 30th, 2023 and will be monitored on a yearly basis by the Dir. of Maintenance and reviewed at the Quality/Safety Meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Campion	Administrator	09/13/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 200	Continued From page 1 revealed the cross-corridor doors from the hospital main building (building 3) to building 5 (clinic with the main entrance) were equipped with magnetic locks at the top of the ninety-minute fire-rated doors. The doors were marked as EXIT doors. Further observation revealed other cross-corridor doors with magnetic locks from building 3 to building 4, to the assisted living corridor, to the assisted living dietary area. A fifth set of magnet locks were in place for the cross-corridor doors from building 4 (wellness) to building 5 (clinic). 2. There was no documentation indicating the magnetically locked doors had been tested for function as being tied into the automatic sprinkler system or working as delayed egress magnetic locks. There was no required signage for delayed egress locks as required by NFPA 101 Section 7.2.1.6 at any of the door locations. There was no documentation of installation adherence to the Life Safety Code or installation approval by the authority having jurisdiction. 3. Interview with the environmental services director at the time of the above observation revealed the doors could have been locked by a button located at the nurse's station when a security threat was determined. Further interview with the administrator at 11:45 a.m. revealed the doors could have been unlocked with computer software by four or five people at the hospital. He stated the magnetic locks were installed approximately three years ago by the previous administrator. Failure to provide egress doors as required increases the risk of death or injury due to fire.	K 200		

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	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

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AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

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K 200	Continued From page 2 The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 200	**K 353** AHCMH will implement a new policy that covers the consistent and regular maintenance & preventive schedule that must be maintained for the Sprinkler System. This policy will be overseen by the Dir. of Maintenance. This policy will include the required Quarterly Flow Testing, Annual inspection, and the 5-year Obstruction inspection. At this time, Quarterly flow testing and the 5-year inspection will be conducted by the vendor, Western States. Western States performed their Quarterly Flow test and obstruction inspection on 9/12/2023. The policy and maintenance schedule will be reviewed on a quarterly basis by the Quality and Safety Committee, which includes the Dir. of Maintenance, Administrator, and other key dept. directors in the facility. As part of the policy, a maintenance schedule has been created and maintained by the Dir. of Environmental Services/Maintenance & Administrator to ensure the proper maintenance and testing of the system on its required quarterly, annual, and 5-yr basis. The Dir. of Maintenance will also post proper signage for the Sprinkler Risers two control valves, and one test and drain valve as well as other required signage areas. This will be completed by September 30th, 2023.	9/30/2023
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: A. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow testing and a 5-year obstruction inspection not completed). Findings include: 1.a. Record review on 8/15/23 at 10:15 a.m. revealed no documentation that the required quarterly flow tests had been performed in 2020, 2021, 2022, and 2023. Quarterly flow testing and	K 353		

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K 353	Continued From page 3 documentation is required by the National Fire Protection Association (NFPA) 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 details all the required preventive maintenance for the NFPA 13 sprinkler system. b. Record review on 8/15/23 at 10:20 a.m. revealed the 5-year internal obstruction inspection was last performed on 6/12/18. The inspection was two months overdue. B. Based on record review and interview, the provider failed to maintain automatic sprinklers in reliable operating condition (valve signage). Findings include: 1. Record review on 8/15/23 at 10:20 a.m. of the annual automatic fire sprinkler system report dated 4/7/23 revealed the sprinkler riser was missing signage for two control valves and one test and drain valve. Interview with the environmental services director at the time of the record review confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected three of numerous required tests on the automatic sprinkler system.	K 353		
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		

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	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 712	Continued From page 4 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills and corresponding documentation). Findings include: 1. Record review on 8/15/23 at 10:05 a.m. revealed there was no documentation of fire drills other than 7/6/23 (2:57 p.m.), 6/29/23 (19:30), 5/23/23 (11:40 a.m.), 4/7/23 (11:00 a.m.), 11/8/22 (3:15 p.m.), 1/28/21, (3:15 p.m.), 9/4/20, and 8/26/20. The provider had two nursing shifts for the hospital. Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions per NFPA 101, Life Safety Code Section 19.7.1.4. Fire drills may be conducted without disturbing patients by choosing the location of the simulated emergency in advance and by closing the doors to the patients' rooms or wards in the vicinity prior to initiation of the drill. The purpose of the fire drill was to test and evaluate the efficiency, knowledge, and response of institutional personnel in implementing the facility fire emergency plan. Fire drills should be scheduled on a random basis to ensure that personnel in health care facilities are drilled not less than once	K 712	K 712 AHCMH will update and educate staff and leaders on the facility Fire Plan & Procedures Policy upon hire, through monthly fire drills, and their annual education. Each Department director is responsible for the onboarding education of new employees. Annual education will be provided via the Annual Learning Center online education in May of each year. The Dir. of Maintenance/EVS will place a standing agenda item on each dept. leader meeting to address the scheduling of the next month's Fire Drill and during which shift it needs to occur. The Dir. of Maintenance/EVS will also be responsible for overseeing and conducting each monthly fire drill and providing the necessary education given the outcomes of each fire drill. The Dir. of Maintenance will maintain and update the fire drill logbook after the completion of each monthly fire drill. For the first year, The fire drill logbook will be reviewed monthly at each department leader meeting by the Administrator to ensure compliance. After the first year, it will be reviewed on a quarterly basis, but will maintain monthly scheduling of the next month's fire drill on the dept. leader agenda. For quality purposes, the Administrator and Quality Committee will review any learning objectives and opportunities derived from the fire drill to discuss with the leadership team and implement necessary changes to address gaps or weaknesses identified by the drill.	9/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 712	Continued From page 5 in each 3-month period. 2. Record review on 8/15/23 at 10:10 a.m. revealed there was no documentation of transmission of the fire alarm signal during fire drills on the fire drill form. That documentation was to include verification of the time of the reception of the fire alarm signal at the monitoring agency and the individual at that location who verified the signal reception. Interview with the environmental services director at the time of the record review confirmed those findings. He stated the provider did not perform all of the required fire drills during the Covid-19 pandemic. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		
K 919	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to install a remote stop button for the generator. Findings include: 1. Observation on 8/15/23 at 11:00 a.m. revealed there was not an emergency stop button installed for the generator at a remote location. Interview	K 919	**K 919** The Director of Maintenance/EVS has contracted with Hughes Electric to install a remote stop button for the generator external to the generator so that in the case of emergency, it can be stopped remotely prior to Sept. 30, 2023. Upon completion, the Dir. of Maintenance will provide documentation of completion to the Administrator. There are no metrics or data to be monitored for this Plan of Correction.	9/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 03 - MAIN B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

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K 919	Continued From page 6 with the environmental services director at the time of the observation revealed there was an emergency stop button inside the generator casing enclosure. He was unaware of the remote stop requirement for the generator. The deficiency affected a single location required to be equipped with a remote emergency stop.	K 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 04 - WELLNESS BUILDING B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/15/23. Avera Hand County Memorial Hospital and Clinic (wellness building-building 04) was found not in compliance with 42 CFR 485.623 (d)(1) requirements for critical access hospitals. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified at K200 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	**K 200** Avera Hand County Memorial Hospital (AHCMH) will test the functionality of the magnetically locked doors via the Facility Lockdown system on 9/14/2023 to test whether or not they are tied to the automatic sprinkler system and are working as delayed egress magnetic locks. The testing will be conducted and overseen by the Dir. of Environmental Services/Maintenance. The current system when only in lockdown operates on a 30 second egress. This will be completed by September 30th, 2023.	9/30/2023
K 200	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the provider failed to provide egress doors as required at one of one cross-corridor exit door locations in building 4 (corridor connection to building 5). Findings include:	K 200	AHCMH will also place the required signage as required by NFPA 101 Section 7.2.1.6 at the required door locations by September 30th, 2023. Documentation of installation adherence to the Life Safety Code will be completed upon the testing of the Lockdown system coinciding with the testing of the Automatic Sprinkler system. A policy will be developed by the Administrator and Dir. of Maintenance/EVS to address the specifics of how each system works individually and what process must be followed in the event that both are activated at the same time. As part of the Lockdown policy, it will be implemented that yearly, AHCMH will test the lockdown system in conjunction with the sprinkler system to ensure the egress door system is working as it is designed to work. This policy will be created and implemented by September 30th, 2023 and will be monitored on a yearly basis by the Dir. of Maintenance and reviewed at the Quality/Safety Meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Campion	Administrator	9/13/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 04 - WELLNESS BUILDING B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 200	Continued From page 1 1. Observation beginning at 9:45 a.m. on 8/15/23 revealed the cross-corridor doors from the hospital wellness building (building 4) to building 3 (main hospital building) and building 5 (clinic with the main entrance) were equipped with magnetic locks at the top of the ninety-minute fire-rated doors. The doors were marked as EXIT doors. 2. There was no documentation indicating the magnetically locked doors had been tested for function as being tied into the automatic sprinkler system or working as delayed egress magnetic locks. There was no required signage for delayed egress locks as required by NFPA 101 Section 7.2.1.6 at any of the door locations. There was no documentation of installation adherence to the Life Safety Code or installation approval by the authority having jurisdiction. 3. Interview with the environmental services director at the time of the above observation revealed the doors could have been locked by a button located at the nurse's station when a security threat was determined. Further interview with the administrator at 11:45 a.m. revealed the doors could have been unlocked with computer software by four or five people at the hospital. He stated the magnetic locks were installed approximately three years ago by the previous administrator. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3),	K 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 04 - WELLNESS BUILDING B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 200	Continued From page 2 7.2.1.6.2(3)(a)	K 200		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: A. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow testing and a 5-year obstruction inspection not completed). Findings include: 1.a. Record review on 8/15/23 at 10:15 a.m. revealed no documentation the required quarterly flow tests had not been performed in 2020, 2021, 2022, and 2023. Quarterly flow testing and documentation is required by the National Fire Protection Association (NFPA) 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25	K 353	K 353 AHCMH will implement a new policy that covers the consistent and regular maintenance & preventive schedule that must be maintained for the Sprinkler System. This policy will be overseen by the Dir. of Maintenance. This policy will include the required Quarterly Flow Testing, Annual inspection, and the 5-year Obstruction inspection. At this time, Quarterly flow testing and the 5-year inspection will be conducted by the vendor, Western States. Western States performed their Quarterly Flow test and obstruction inspection on 9/12/2023. The policy and maintenance schedule will be reviewed on a quarterly basis by the Quality and Safety Committee, which includes the Dir. of Maintenance, Administrator, and other key dept. directors in the facility. As part of the policy, a maintenance schedule has been created and maintained by the Dir. of Environmental Services/Maintenance & Administrator to ensure the proper maintenance and testing of the system on its required quarterly, annual, and 5-yr basis. The Dir. of Maintenance will also post proper signage for the Sprinkler Risers two control valves, and one test and drain valve as well as other required signage areas. This will be completed by September 30th, 2023.	9/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 04 - WELLNESS BUILDING B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 353	Continued From page 3 details all the required preventive maintenance for the NFPA 13 sprinkler system. b. Record review on 8/15/23 at 10:20 a.m. revealed the 5-year internal obstruction inspection was last performed on 6/12/18. The inspection was two months overdue. B. Based on record review and interview, the provider failed to maintain automatic sprinklers in reliable operating condition (valve signage). Findings include: 1. Record review on 8/15/23 at 10:20 a.m. of the annual automatic fire sprinkler system report dated 4/7/23 revealed the sprinkler riser was missing signage for two control valves and one test and drain valve. Interview with the environmental services director at the time of the record review confirmed those conditions.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 05 - CLINIC B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/15/23. Avera Hand County Memorial Hospital and Clinic (wellness building-building 05) was found not in compliance with 42 CFR 485.623 (d)(1) requirements for critical access hospitals. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified at K200 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	**K 200** Avera Hand County Memorial Hospital (AHCMH) will test the functionality of the magnetically locked doors via the Facility Lockdown system on 9/14/2023 to test whether or not they are tied to the automatic sprinkler system and are working as delayed egress magnetic locks. The testing will be conducted and overseen by the Dir. of Environmental Services/Maintenance. The current system when only in lockdown operates on a 30 second egress. This will be completed by September 30th, 2023.	9/30/2023
K 200	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the provider failed to provide egress doors as required at two of two cross-corridor exit door locations in building 5 (corridor connection to buildings 3 and 4). Findings include:	K 200	AHCMH will also place the required signage as required by NFPA 101 Section 7.2.1.6 at the required door locations by September 30th, 2023. Documentation of installation adherence to the Life Safety Code will be completed upon the testing of the Lockdown system coinciding with the testing of the Automatic Sprinkler system. A policy will be developed by the Administrator and Dir. of Maintenance/EVS to address the specifics of how each system works individually and what process must be followed in the event that both are activated at the same time. As part of the Lockdown policy, it will be implemented that yearly, AHCMH will test the lockdown system in conjunction with the sprinkler system to ensure the egress door system is working as it is designed to work. This policy will be created and implemented by September 30th, 2023 and will be monitored on a yearly basis by the Dir. of Maintenance and reviewed at the Quality/Safety Meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Campion	Administrator	8/31/2023

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
	431337	A. BUILDING 05 - CLINIC B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 200	Continued From page 1 1. Observation beginning at 9:45 a.m. on 8/15/23 revealed the cross-corridor doors from the hospital clinic building (building 5) to building 3 (main hospital building) and building 4 (wellness building) were equipped with magnetic locks at the top of the ninety-minute fire-rated doors. The doors were marked as EXIT doors. 2. There was no documentation indicating the magnetically locked doors had been tested for function as being tied into the automatic sprinkler system or working as delayed egress magnetic locks. There was no required signage for delayed egress locks as required by NFPA 101 Section 7.2.1.6 at any of the door locations. There was no documentation of installation adherence to the Life Safety Code or installation approval by the authority having jurisdiction. 3. Interview with the environmental services director at the time of the above observation revealed the doors could have been locked by a button located at the nurse's station when a security threat was determined. Further interview with the administrator at 11:45 a.m. revealed the doors could be unlocked with computer software by four or five people at the hospital. He stated the magnetic locks were installed approximately three years ago by the previous administrator. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 05 - CLINIC B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 353	Continued From page 2	K 353		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: A. Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow testing and 5-year obstruction inspection not done). Findings include: 1.a. Record review on 8/15/23 at 10:15 a.m. revealed no documentation the required quarterly flow tests had not been performed in 2020, 2021, 2022, and 2023. Quarterly flow testing and documentation is required by the National Fire Protection Association (NFPA) 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 details all the required preventive maintenance for the NFPA 13 sprinkler system.	K 353	**K 353** AHCMH will implement a new policy that covers the consistent and regular maintenance & preventive schedule that must be maintained for the Sprinkler System. This policy will be overseen by the Dir. of Maintenance. This policy will include the required Quarterly Flow Testing, Annual inspection, and the 5-year Obstruction inspection. At this time, Quarterly flow testing and the 5-year inspection will be conducted by the vendor, Western States. Western States performed their Quarterly Flow test and obstruction inspection on 9/12/2023. The policy and maintenance schedule will be reviewed on a quarterly basis by the Quality and Safety Committee, which includes the Dir. of Maintenance, Administrator, and other key dept. directors in the facility. As part of the policy, a maintenance schedule has been created and maintained by the Dir. of Environmental Services/Maintenance & Administrator to ensure the proper maintenance and testing of the system on its required quarterly, annual, and 5-yr basis. The Dir. of Maintenance will also post proper signage for the Sprinkler Risers two control valves, and one test and drain valve as well as other required signage areas. This will be completed by September 30th, 2023.	9/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING 05 - CLINIC B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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 353	Continued From page 3 b. Record review on 8/15/23 at 10:20 a.m. revealed the 5-year internal obstruction inspection was last performed on 6/12/18. The inspection was two months overdue. B. Based on record review and interview, the provider failed to maintain automatic sprinklers in reliable operating condition (valve signage). Findings include: 1. Record review on 8/15/23 at 10:20 a.m. of the annual automatic fire sprinkler system report dated 4/7/23 revealed the sprinkler riser was missing signage for two control valves and one test and drain valve. Interview with the environmental services director at the time of the above record review confirmed those conditions.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53862S	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND C	300 W 5TH ST MILLER, SD 57362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospitals, Specialized Hospital, and Critical Access Hospital facilities was conducted from 8/15/23 through 8/17/23. Avera Hand County Memorial Hospital and Clinic were found not in compliance with the following requirement: S211.	S 000	**S 211** AHCMH will update and educate staff and leaders on the facility Fire Plan & Procedures Policy upon hire, through monthly fire drills, and their annual education. Each Department director is responsible for the onboarding education of new employees. Annual education will be provided via the Annual Learning Center online education in May of each year. The Dir. of Maintenance/EVS will place a standing agenda item on each dept. leader meeting to address the scheduling of the next month's Fire Drill and during which shift it needs to occur. The Dir. of Maintenance/EVS will also be responsible for overseeing and conducting each monthly fire drill and providing the necessary education given the outcomes of each fire drill. The Dir. of Maintenance will maintain and update the fire drill logbook after the completion of each monthly fire drill. For the first year, The fire drill logbook will be reviewed monthly at each department leader meeting by the Administrator to ensure compliance. After the first year, it will be reviewed on a quarterly basis, but will maintain monthly scheduling of the next month's fire drill on the dept. leader agenda. For quality purposes, the Administrator and Quality Committee will review any learning objectives and opportunities derived from the fire drill to discuss with the leadership team and implement necessary changes to address gaps or weaknesses identified by the drill.	
S 211	44:75:03:02 General Fire Safety Each licensed health care facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to sound the fire alarm each month for 2021, 2022, and 2023. Findings include: 1. Record review beginning on 8/15/23 at 10:00 a.m. revealed there was no documentation available indicating the facility's fire alarm had been sounded each month for 2021, 2022, and 2023. Periodic inspections by the sprinkler contractor, fire alarm contractor, and a handful of fire drills during those time periods did sound the fire alarm but fell short of the monthly requirement. Interview with the environmental services director at the time of the record review confirmed that	S 211		9/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew Campion
TITLE: Administrator
(X6) DATE: 9/13/23

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
	53862S	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND C	300 W 5TH ST MILLER, SD 57362

(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 211	Continued From page 1 finding.	S 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING _____ B. WING _____	R 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	300 W 5TH ST MILLER, SD 57362

(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
{C 000}	INITIAL COMMENTS A revisit survey was conducted on 10/3/23 for compliance with 42 CFR Part 484, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals for all previous deficiencies cited on 8/16/23. All deficiencies have been corrected and no new non-compliance was found. Avera Hand County Memorial Hospital and Clinic was found in compliance with all regulations surveyed.	{C 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING **03 - MAIN** B. WING _____	R **10/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	**300 W 5TH ST** **MILLER, SD 57362**

(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 onsite revisit survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/5/23. Avera Hand County Memorial Hospital and Clinic (main building-building 03) was found in compliance with 42 CFR 485.623 (d)(1) requirements for Critical Access Hospitals.	{K 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING **04 - WELLNESS BUILDING** B. WING _____	R **10/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA HAND COUNTY MEMORIAL HOSPITAL AND CLINIC	**300 W 5TH ST** **MILLER, SD 57362**

(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 onsite revisit survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/5/23. Avera Hand County Memorial Hospital and Clinic (wellness building-building 04) was found in compliance with 42 CFR 485.623 (d)(1) requirements for Critical Access Hospitals.	{K 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431337	A. BUILDING **05 - CLINIC** B. WING _____	R **10/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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