STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430008	A. BUILDING _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKINGS HEALTH SYSTEM	300 22ND AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A recertification survey for compliance with 42 CFR Part 482, Subpart A - D, requirements for Hospitals and Long-Term Care Services ("swing beds"), was conducted from 3/4/25 through 3/6/25. Brookings Health System was found not in compliance with the following requirements: A358, A619, and A747.	A 000		
A 358	MEDICAL STAFF RESPONSIBILITIES - H&P CFR(s): 482.22(c)(5)(i) [The bylaws must:] Include a requirement that-- (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(5)(iii) of this section. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oral and maxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. This STANDARD is not met as evidenced by: Based on record review, medical staff bylaws review, and interviews, the provider failed to ensure a presurgical history and physical (H&P) had been performed within thirty days prior to surgery for one of two sampled patients (36) who had a colonoscopy. Findings include: 1. Review of the patient 36's record revealed: *He had been admitted on 12/2/24 for a	A 358	Education was provided to Surgeon Q on the Medical Staff Bylaw requirement of the pre-surgical 30-day H&P by the Director of Surgical Services March 7, 2025. Education will be provided with surgery intake staff on H&P requirements by Director of Surgical Services. An audit will be done by the Director of Surgical Services monthly X 3 months to ensure all staff have received the education. Audit findings will be reported by Director of Surgical Services to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee. An audit tool will be developed, and audits will be completed by the Director of Surgical Services on all scheduled surgeries for 6 weeks and then 10 surgical cases per week X 4 weeks and include: • verification of the presence of a pre-surgical H&P within 30 days of surgery • H&P is dated, timed and authenticated • H&P is legible Audit findings will be reported by Director of Surgical Services to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	4/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Merkley	President & CEO	4/1/2025

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

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A 358	Continued From page 1	A 358		

colonoscopy.
*The colonoscopy was performed by Surgeon Q.
*His H&P performed on 1/11/24.
*There was a date of 12/2/24 with some writing and a signature at the end of the H&P.
* The signature at the end of the H&P was ineligible and not timed to support when it had been reviewed.

Review of the provider's 12/18/24 Bylaws of the Medial Staff revealed on page 22, "A complete admission history and physical examination or equivalent medical consultation shall be performed and recorded no more than 30 (thirty) days prior to admission or within 24 (twenty-four) hours after admission. The medical history and physical examination must be placed in the medical record
within twenty-four (24) hours after admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. An updated examination of the patient must be documented in the chart by the attending physician or surgeon, to include any changes in the patient 's condition if the History & Physical exam is completed within 30 days before admission."

Interview on 3/6/25 at 10:20 a.m. with Director of Nursing-Surgery D revealed:
*Surgeon Q would have signed the patient's H&P that was older than two months if the patient was healthy.
*She agreed that the surgeon's documentation on the patients 36's H&P that was used was illegible, with no time documented of when the H&P was reviewed.

Interview on 3/6/25 at 11:26 a.m. with Chief

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A 358	Continued From page 2 Nursing Officer L revealed she: *Confirmed that their policy was to have a H&P performed within 30 days of a patient's surgical procedure. *Agreed that the facility was not meeting the Bylaws of the Medical Staff.	A 358		
A 619	ORGANIZATION CFR(s): 482.28(a) Organization This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain: *The cleanliness of the walk-in-cooler fan guards and cooling fins in the kitchen. *The cleanliness of the walk-in-freezer fan guards, cooling fins, floor, and ceiling in the kitrchen. *The cleanliness of the top of the convection oven in the kitchen. *The smooth and easily cleanable surface of the floor in front of the convection oven in the kitchen. *The smooth and easily cleanable surface of three of three observed chopper/scraper handles in the kitchen . *The cleanliness of the walls behind the three-compartment sink in the kitchen. *The cleanliness of the walls east of the grill in the cafeteria area. *The cleanliness of the door seals and bottom of the reach-in-freezer west of the grill in the cafeteria area. *The cleanliness of the door seals for the reach-in- cooler in the cafeteria area. Findings include: 1. Observation and interview on 3/5/25 at 3:00	A 619	1. Walk-in cooler fan guards and cooling fins were cleaned by Maintenance Supervisor on March 14, 2025. Cleaning of walk-in cooler fan guards, sprinkler head and cooling fins were added to maintenance checklist for monthly checks. An audit tool will be developed, and audits will be completed by the Food Service Director monthly X 6 months to check for residue -free fan guards, sprinkler head and cooling fins. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	4/14/2025

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A 619	Continued From page 3 p.m. with dietary manager P of the walk-in cooler in the kitchen revealed: *The fan guards on the front of the cooling unit were covered with a moderate amount of a grey fuzzy residue. *The cooling fins on the back of the cooling unit were completely covered with a grey fuzzy residue. *The fire sprinkler head for the walk-in cooler was also covered with a grey fuzzy residue. *She had not noticed the grey fuzzy residue in those areas. 2. Observation and interview on 3/5/25 at 3:05 p.m. with dietary manager P in the walk-in freezer revealed: *There was a puddle of red ice on the floor where something had spilled. *There was about six inches thickness of frost building up in the southeast and southwest corners of the ceiling. *There was about ten inches of an icicle forming from the frost and starting to freeze on a box of food. *The fan guard on the front of the cooling unit had clumps of grey fuzzy residue on the bottom third of the fan guard. *She was not aware of the grey fuzzy residue in the fan grates. *She was aware of the frost and ice on the floor. *She had not found a good time yet to take the walk-in freezer out of service to defrost and clean it. 3. Observation and interview on 3/5/25 at 3:15 p.m. with dietary manager P at the convection oven in the kitchen. *There was a layer of food crumbs and grease residue approximately a sixteenth of an inch deep	A 619	2. Spill on floor was cleaned by Food Service Director on March 5, 2025. Ice and frost build up will be removed from the walk-in freezer by Food Service Director. Fan guards, cooling fins, fan grates of the walk-in freezer, kitchen floor and kitchen ceiling were cleaned by Maintenance Supervisor March 14, 2025. Cleaning of walk-in cooler fan guards, fan grates and cooling fins, kitchen floor and ceiling, ice buildup checks will be added to maintenance checklist for monthly checks. An audit tool will be developed, and audits will be completed by the Food Service Director monthly X 6 to check that fan guards, fan grates, cooling fins, kitchen floor and ceiling are clean. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend the audits as deemed appropriate by the committee. 3. Convection oven was cleaned by Food Service Director March 10, 2025. Cleaning of convection oven was added to dietary cleaning checklist for weekly cleaning. An audit tool will be developed, and audits will be completed by the Food Service Director weekly X 12 to check for cleaning of convection oven. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	

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A 619	Continued From page 4 across the top of the convection oven. *She was not aware of the buildup of residue on top of the convection oven. 4. Observation and interview on 3/5/25 at 3:17 p.m. with dietary manager P of the floor in front of the convection oven revealed: *There were five (four inch by four inch) tiles missing from the floor. *Where the tiles were missing was a black layer of what appeared to be thinset mortar approximately one quarter of an inch thick. *There were pieces of the black layer missing in two areas. One was about four inches by four inches. The other about two inches by two inches. Where the black layer was missing you could see another tile floor. *The missing tiles and missing black layer created an uneven surface that was not easy to clean. *There was a grey, brown residue around the edges where there was a level change. *The floor was damaged before she started working there in October of 2024. *She was not aware if the previous dietary manager had submitted any work orders to have the floor repaired. *She had not put in any work orders to have the floor repaired. *She agreed it should have been repaired. 5. Observation and interview on 3/5/25 at 3:20 p.m. with dietary manager P regarding three of three observed chopper/scrapers revealed: *Each chopper/scrapper had melted plastic handles. The plastic was not smooth and easily cleanable where the plastic was melted. One had a crack in the plastic down to the blade. *She agreed those handles were no longer	A 619	4. Floor was repaired March 20, 2025. Inspecting floor integrity was added to dietary cleaning checklist by Food Service Director for monthly check. An audit tool will be developed, and audits will be completed by the Food Service Director monthly X 6 to check for floor integrity. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee. 5. Cracked and damaged utensils were discarded March 10, 2025. All other kitchen utensils were checked for damage by Food Service Director. Damaged kitchen utensil checks will be added to dietary monthly checklist by Food Service Director. An audit tool will be developed, and audits will be completed by the Food Service Director monthly X 3 to check for damaged kitchen utensils. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee. 6. Wall behind the 3-compartment sink was cleaned March 10, 2025. Cleanliness of the wall behind the 3-compartment sink was added to dietary cleaning checklist by Food Service Director for weekly cleaning. An audit tool will be developed, and audits will be completed by the Food Service Director weekly X 8 weeks and then every other week X 8 weeks to check for cleanliness of wall behind the sink.	

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A 619	Continued From page 5 cleanable. 6. Observation and interview on 3/5/25 at 3:30 p.m. with dietary manager P regarding the wall behind the three-compartment sink revealed: *There were multiple small spots of dried food stuck to the wall. *It was unknown when the last time the wall had been cleaned. *That wall was not on a cleaning schedule. 7. Observation and interview on 3/5/25 at 3:35 p.m. with dietary manager P regarding the wall in the cafeteria east of the grill revealed: *The wall had a yellowish sticky residue covering it. There was a slight grey fuzzy residue over the yellow sticky residue. *It was unknown when the last time the wall had been cleaned. *That wall was not on a cleaning schedule. 8. Observation and interview on 3/5/25 at 3:40 p.m. with dietary manager P regarding the reach-in-freezer west of the grill in the cafeteria area revealed: *The inside bottom of the freezer had a moderate of brown breadcrumbs and shredded cheese covering it. *The door seal also had brown breadcrumbs and shredded cheese filling the grooves. *It was unknown when the last time the freezer had been cleaned. *That freezer was not on a cleaning schedule. 9. Observation and interview on 3/5/25 at 3:45 p.m. with dietary manager P regarding the reach-in-cooler in the cafeteria area revealed: *There was a moderate amount of shredded cheese and breadcrumbs in the grooves of the	A 619	6. cont. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee. 7. Wall behind the grill was cleaned March 10, 2025. Cleaning of the wall behind the grill was added to dietary cleaning checklist for weekly cleaning. An audit tool will be developed, and audits will be completed by the Food Service Director weekly X 8 weeks and then every other week X 8 weeks to check for cleanliness of the wall behind the grill. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend the audits as deemed appropriate by the committee. 8. Reach in freezer, including door seal, west of the grill was cleaned March 10, 2025. Cleaning of the reach-in freezer was added to dietary cleaning checklist for monthly cleaning. An audit tool was developed, and audits will be completed by the Food Service Director monthly X 6 months to check for cleanliness of reach-in freezer west of the grill. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	

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A 619	Continued From page 6 door seal. *It was unknown when the last time the reach-in-cooler had been cleaned. *That reach-in-cooler was not on a cleaning schedule. 10. Interview on 3/5/25 at 4:00 p.m. with dietary manager P regarding the items listed above revealed: *She had been dietary manager since October of 2024. *She agreed the items found should have been cleaned and were not on a cleaning schedule. *She agreed she should have contacted maintenance regarding the floor and frost build up in the walk-in-freezer.	A 619	9. Reach-in cooler in the cafeteria was cleaned on March 10, 2025. Cleaning of the reach-in cooler was added to dietary cleaning checklist for monthly cleaning. An audit tool was developed, and audits will be completed by the Food Service Director monthly X 6 months to check for cleanliness of the reach-in cooler in the cafeteria. Audit findings will be reported by Food Service Director to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	
A 747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on observation, policy review, review of manufacturer's instruction for use (IFU), and	A 747	1. Glucometer and docking station on IP and OB were cleaned on March 4, 2025. Education on the facility "Nova StatStrip Glucometer" policy will be reviewed with IPC nurses by Inpatient Director. An audit will be done by the Director of Inpatient Care monthly X 3 months to ensure all staff have received the education. Audit findings will be reported by Director of Inpatient Care to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee. Education on the facility "Nova StatStrip Glucometer" policy will be reviewed with OB nurses by OB Director. An audit will be done by the Director of OB monthly X 3 months to ensure all staff have received the education.	4/14/2025

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A 747	Continued From page 7 interview, the provider failed to ensure: *Three of three observed glucometers had been cleaned and disinfected properly prior to patient use. *Multiple surgical instruments wrapped with surgical tape were free of cracks, rips, tears, and discoloration. *Multiple surgical instruments had surgical tape wrapped around the instrument, applied flat, and without gaps per manufacturer's IFU. *All contaminated instruments containing blood and bodily fluids from two of two tables in the operating room (OR) had been transported in a sealed, puncture resistant, leak proof container. *There was sufficient exhaust air flow for one of one soiled linen room attached to the laundry. Findings include: 1. Observation and interview on 3/4/25 at 10:40 a.m. with director nursing-women's center A in the clean storage room in the OB (obstetrics) unit revealed: *One glucometer placed in a docking station revealed it had visible blood near the glucometer strip insertion site. *The docking station used to store the glucometer had visible dust and debris on it. *Glucometers placed in the docking station meant they had been cleaned, disinfected, and were ready for patient use. *She: -Confirmed there was visible blood on the glucometer and had not been cleaned properly prior to docking it in the station. -Confirmed the docking station had dust and debris and had not been a part of their cleaning process. *She had removed the bloody glucometer to disinfect it.	A 747	1. Continued from page 7 Audit findings will be reported by Director of OB to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee An audit tool was developed, and audits will be completed by the Infection Preventionist 2 X weekly X 8 weeks and then weekly X 8 weeks to check for proper cleaning of glucometers and docking station on IPC and OB units. Audit findings will be reported by the Infection Preventionist to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	

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A 747	Continued From page 8 Observation and interview on 3/4/25 at 1:10 p.m. with director of inpatient care B in the North medication room revealed: *A glucometer placed in a docking station had a brown substance near the glucometer strip insertion site. *The docking station used to store the glucometer had a thick layer of dust and debris on it. *Director of inpatient care B confirmed the above observations. Observation and interview on 3/4/25 at 1:20 p.m. with director of inpatient care B and registered nurse (RN) clinical care coordinator C in the South medication room revealed: *A glucometer placed in a docking station had visible blood near the glucometer strip insertion site and contained tape residue. *RN clinical care coordinator C verified the visible blood and tape residue and proceeded to clean the glucometer with a disinfectant wipe. *The docking station used to store the glucometer had a thick layer of dust and debris on it. *Director of inpatient care B and RN, clinical care coordinator C confirmed glucometers placed in the docking station meant they had been cleaned, disinfected, and were ready for patient use. *They confirmed the docking station had not been a part of their cleaning process. Interview on 3/4/25 at 3:00 p.m. with director of inpatient care B revealed: *Glucometer machines should have been cleaned with a disinfectant wipe between patients. *Staff should have inspected the glucometer prior to placing it in the docking station to ensure it was appropriately cleaned.	A 747		

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A 747	Continued From page 9 Review of the provider's 8/29/18 Nova StatStrip Glucometer's policy revealed: *"The meter must be checked for cleanliness; cleaned when necessary before use and cleaned after each use. *Wipe the meter between patients with a disposable Super Sani-Cloth Germicidal agent or hospital based cleaner. Wipe the surface area of the test strip port making sure that no fluid enters the port." Review of the 2024 StatStrip Glucose Meter instructions for use manual revealed: *"The StatStrip Glucose Hospital Meters should be cleaned and disinfected after each patient use to minimize the risk of transmission of blood-borne pathogens between patient and healthcare professionals. *1. Clean the Meter. -Remove a fresh germicidal wipe from the canister. -Wipe the external surface of the meter thoroughly with a fresh germicidal disinfecting bleach wipe. 2. Disinfect the Meter. -Using a new, fresh germicidal bleach wipe, thoroughly wipe the surface of the meter (top, bottom, left, and right sides) a minimum of 3 times horizontally followed by 3 times vertically avoiding the bar code scanner and electrical connector. -Gently wipe the surface area of the test strip port making sure that no fluid enters the port." 2. Observation on 3/5/25 at 8:45 a.m. in the sterile core and clean supply area of the OR revealed: *A forcep contained within a sterilized surgical	A 747	2. All surgical instruments needing sterilization for patient use will have the tape removed. Education with surgical staff on the policy "Care of instruments in Non-Surgical Departments" will be completed by Director of Surgical Services. An audit will be done by the Director of Surgical Services monthly X 3 months to ensure all staff have received the education. Audit findings will be reported by Director of Surgical Services to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee An audit tool was developed, and audits will be completed by the Infection Preventionist 2 X weekly X 8 weeks and then weekly X 4 weeks to check for tape-free surgical instruments. Audit findings will be reported by the Infection Preventionist to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	

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A 747	Continued From page 10 pack and ready for patient use had surgical tape residue and brown discoloration. *A tweezer contained within a surgical pack and ready for patient use had tape residue. *A hip retractor pan containing multiple surgical instruments revealed the surgical tape had: -Been placed flat on the instrument. -Not been wrapped 1.5 times around the instrument per the manufacturer's IFU. -Not been laid flat without gaps. -Had cracks, tears, and discoloration. Observation and interview on 3/5/25 at 8:50 a.m. with director nursing-surgery D in OR #3 revealed: *A scissor contained within a surgical pack and ready for patient use had two pieces of surgical tape wrapped more than 1.5 times around and had not been laid flat without gaps per the manufacturer's IFU. *She confirmed the above findings and would have the sterile processing department re-tape the instruments according to the manufacturer's IFU. *She confirmed the hip retractor pan was not owned by the provider and was supplied per the surgeon's preference. *She agreed instruments brought into the facility should have been taped according to the manufacturer's IFU. Observation and interview on 3/5/25 at 1:30 p.m. with director nursing-surgery D and certified surgical technician (CST) E in the sterile processing revealed: *A counter containing multiple surgical instruments with surgical tape from various specialty clinics had been cleaned and needed to be inspected.	A 747		

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	430008	A. BUILDING _____ B. WING _____	03/06/2025

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A 747	Continued From page 11 *The surgical instrument's contained tape that had been: -Lying flat on the instrument. -Not wrapped 1.5 times around. -Wrapped more than 1.5 times around. -Cracked, frayed, and were not lying flat without gaps. *CST E confirmed: -The specialty clinic staff were to tape their own instruments. -She was not sure if the clinic staff had been properly trained to tape surgical instruments according to the manufacturer's IFU . -Instruments in the OR should not have contained surgical tape. *Director of nursing-surgery D and CST E agreed with the above findings and those issues created the potential of bacteria to remain on surgical instruments. Interview on 3/6/25 at 8:20 a.m. with clinic director H revealed: *The sterile processing department would have done the taping on the instruments for the specialty clinics. *Each specialty clinic was assigned a specific color of tape so when the instruments were sent for sterilization, the instruments are returned to the correct clinic. *Clinic staff had not been trained to properly tape surgical instruments. *Staff were educated to inspect the instruments prior to use which included identifying tape issues. Interview and observation on 3/6/25 at 8:30 a.m. with RN I in the general surgery clinic revealed: *In the procedure room, there was a cabinet containing packaged sterilized instruments ready	A 747		

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A 747	Continued From page 12	A 747		

for patient use.
*Two packaged instruments that had been pulled randomly out of bins had not been taped according to manufacturer's IFU.
*She confirmed taping was done by the sterile processing department.

Interview and observation on 3/6/25 at 8:40 a.m. with RN J and clinic director H in the podiatry clinic revealed:
*In the procedure room, there were multiple surgical instruments that had been sterilized and packaged.
*The surgical instrument's contained tape that had been:
-Lying flat on the instrument.
-Not wrapped 1.5 times around.
-Wrapped more than 1.5 times around.
-Cracked, frayed, and were not lying flat without gaps.
*RN J confirmed staff had not been trained to apply tape to surgical instruments according to the manufacturer's IFU.
*Clinic director H confirmed the above findings and would reach out to sterile processing to correct tape issues on the instruments.

Review of the provider's 8/17/2021 Care of Instruments in Non-Surgical Departments policy revealed: "Visually inspect the entire instrument, paying close attention to grooves, hinges, lumens textured surfaces, and taped areas."

Review of the provider's 2/2021 Care of Instruments policy revealed:
*"Loaner instruments are checked, cleaned, and sterilized before use."
*It did not mention caring for instruments that had been taped.

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A 747	Continued From page 13 Review of the manufacturer's revised 2024 Key Surgical Identification Tape IFU revealed: *"Wrap tape 1.5 times on a stainless-steel instrument. Tape should lay flat without gaps. *Inspect tape prior to each use. Identification tape is not intended as a permanent mark and will discolor, break, chip, or flake over time. *Replace as soon as these are noticed." 3. Observation and interview on 3/5/25 at 11:30 a.m. with CST F in OR #1 revealed: *Multiple surgical instruments including scissors, dilators, and clamps were on a long table with wheels. *Several contaminated instruments had not been placed in containers and were lying flat on a blue surgical towel on the table. *Two round containers with no lids were filled with water sitting on top of the table. *A large red drape containing a biohazard label was then draped over the entire table containing the contaminated instruments and container filled with water and was pushed from the OR into the OR corridor and then rolled to the decontamination room. *She confirmed: -The containers for transporting the used surgical instruments and water did not have lids. -Some instruments could have punctured the drape if they fell off the table. -The above process had been their practice for transporting contaminated instruments to the OR. Interview on 3/5/25 at 11:45 a.m. with CST E in the decontamination room revealed: *Surgical instruments used during the operation were placed into containers with no lids on them. *Some instruments may have been placed on the	A 747	3. Containers with lids will be purchased for transportation of contaminated instruments. OR "Sharps Safety" Policy was updated to reflect lid container requirements for transportation of contaminated instruments. Education with surgical staff on the updated policy "Sharps Safety" will be completed by Director of Surgical Services. An audit will be done by the Director of Surgical Services monthly X 3 months to ensure all staff have received the education. Audit findings will be reported by Director of Surgical Services to the Quality and Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee An audit tool was developed, and audits will be completed by the Director of Surgical Services 3 X weekly X 8 weeks to check that proper containers with lids are being utilized when transporting contaminated instruments. Audit findings will be reported by the Infection Preventionist to the Quality & Safety committee. If a compliance rate of 100% is not met, the Quality and Safety committee may extend audits as deemed appropriate by the committee.	

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A 747	Continued From page 14 table in no containers. *Water was transported in containers with no lids. *The needles and sharp objects had been separated and discarded separately. *The red drape covering the instruments was not sealed, leak proof, or puncture resistant. *She confirmed instruments could have punctured or fell through the drape if they fell off the table. *She confirmed sealed, leak proof containers had not been used to transport contaminated surgical instruments. *The provider followed the Association of perioperative Registered Nurses (AORN) to guide their practice. Observation on 3/5/25 at 2:30 p.m. with CST F from OR #2 to the decontamination room revealed: *Several laparoscopic instruments with sharp scissors on the end had been placed in containers with no lids on a long table with wheels. *A large red drape containing a biohazard label was draped over the table and was pushed from the OR into the OR corridor and then rolled to the decontamination room. *The laparoscopic instruments could have punctured or fell through the drape. *The red drape covering the instruments was not sealed, leak proof, or puncture resistant. Observation and interview on 3/5/25 at 2:40 p.m. with CST G from OR #2 to the decontamination room revealed: *A large red drape containing a biohazard label had been draped over a table with wheels containing contaminated instruments, disposable sharps, and containers filled with water, and it	A 747		

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A 747	Continued From page 15 was pushed from the OR into the OR corridor and then rolled to decontamination room. *Multiple surgical instruments including clamps, scissors, and disposable sharps (needles, scalpels) were lying on top of the table. *One round container with no lid had been filled with water and placed on the table. *The instruments and disposable sharps had not been placed in sealed, leak proof, puncture resistant containers. *She confirmed disposable sharps were transported to the decontamination room because the larger biohazard bins were stored there for staff to dispose of them properly. *She confirmed their process had always been to transport contaminated instruments and water without lids or containers. *She confirmed instruments, and disposable sharps could have punctured or fell through the drape if they fell off the table. Interview on 3/5/25 at 3:20 p.m. with director nursing-surgery D revealed she: *Confirmed contaminated surgical instruments and containers filled with water had not been transported in sealed, leak proof, and puncture resistant containers. *Agreed sharp instruments could have punctured through the red drape and potentially exposed staff to blood-borne pathogens. *Agreed AORN had recommended this practice, and she had been unsure of when this regulation changed. *Confirmed their process had not followed AORN guidelines. 4. Interview on 3/6/25 at 9:25 a.m. with infection preventionist K revealed: *Staff were educated yearly on cleaning of	A 747		

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A 747	Continued From page 16	A 747		

glucometers by clinical coordinator staff and during a skills fair.
*Staff were to clean glucometers at the point of use with an alcohol pad and a disinfectant wipe.
*Audits were conducted at random during surveillance rounds to ensure compliance with the cleaning process.
*She agreed blood left on glucometer machines after having been disinfected put staff and patients at risk for blood-borne pathogens.
*She stated, "Our SOP {standards of practice} states not to use tape on instruments. I swear we have always had a no tape instrument SOP."
-She confirmed the provider did not have that stated in their policy.
*If tape was used on instruments, she would have expected staff to follow the manufacturer's IFU.
*Contaminated surgical instruments were to be placed in an enclosed, rigid tote, labeled biohazard during transportation.
*She had thought that was how surgery staff had been transporting contaminated instruments and sharps.

Review of the provider's 2/2021 Care of Instruments policy revealed:
*"Contaminated instruments:
-Contain during transport in a timely manner, transport to decontamination as soon as possible."

The provider's policy had not specified to transport contaminated instruments in an enclosed, leak proof, puncture resistant container, labeled biohazard.

Review of AORN's 2024 Guidelines for Perioperative Practice: Transport to the Decontamination Area pg. 415 revealed:

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A 747	Continued From page 17 *"7.2. Contaminated instruments must be transported to the decontamination area in a closed container or enclosed transport cart that is: -leak proof, -puncture resistant, -large enough to contain all contents, and -labeled with a fluorescent orange or orange-red label contained a biohazard legend." 5. Observation on 3/5/25 at 9:00 a.m. revealed when the door between the corridor and the soiled linen room attached to the laundry was opened, air from inside the soiled linen room rushed out into the corridor. Observation and interview on 3/5/25 at 9:30 a.m. with environmental services director M regarding the airflow between the soiled linen room and the corridor revealed: *He confirmed the air was coming out of the soiled linen room and into the corridor. *He was not aware the soiled linen room was positively pressured in relation to the corridor. *He agreed the soiled linen room should have been negatively pressured in relation to the corridor. Interview on 3/5/25 at 9:40 with the laundry supervisor O revealed: *She had noticed the air coming out of the soiled linen room and into the corridor about 4 months ago. *She had not told maintenance staff of the issue. Interview on 3/6/25 at 8:30 a.m. with maintenance supervisor N revealed:	A 747	5. Requested HVAC vendor assessment and estimate to provide negative air flow to the soiled linen/utility room. Vendor assessment was completed on March 28, 2025. Vendor recommends renovations to room to create negative air flow. Parts and labor estimated at $20,000 along with a four (4) to six (6) week lag time for completion of work. As an alternative, Maintenance Supervisor will attempt to adjust airflow within room to negatively pressurize the soiled linen room. Airflow into soiled linen room is currently tied into other rooms within that area and adjustments may not allow for enough air to other work and patient care rooms. Nonetheless, adjustments will be made, and monitoring of such adjustments will determine next steps to solve pressurization within laundry soiled linen room. Daily tissue tests will be done X 5 days per week X 3 weeks and then weekly X 8 weeks by Maintenance Supervisor. An auditing tool will be developed by Maintenance Supervisor to monitor test results. The audit findings will be report to the Quality and Safety committee by the Director of EVS. Soiled linen room airflow checks will be added to the monthly maintenance checklist.	

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A 747	Continued From page 18 *He was not aware the soiled linen room was positively pressured in relation to the corridor. *Maintenance staff went on the roof and maintained the exhaust vent for the soiled linen room quarterly. Maintenance staff would ensure it was working. *Maintenance staff never checked to make sure the exhaust airflow from the soiled linen room was sufficient to maintain a negative pressure in the room in relation to the corridor. *He agreed the soiled linen room should have been negatively pressured in relation to the corridor.	A 747		

South Dakota Department of Health

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	10529 S	A. BUILDING: _____ B. WING _____	03/06/2025

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S 000	Compliance/Noncompliance Statement A licensure health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 3/4/25 through 3/6/25. Brookings Health System was found not in compliance with the following requirement: S166.	S 000		
S 166	44:75:02:18(1-8) Occupant Protection The facility shall: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients; (3) Provide a call system for each patient bed and in all toilet rooms and bathing facilities routinely used by patients. The call system must be capable of being easily activated by the patient and must register at a nurses' station serving the unit. A wireless call system may be used; (4) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (5) Prohibit the use of a portable space heater, portable halogen lamp. household-type electric blanket, or household-type heating pad in the facility; (6) Ensure that any light fixture located over a patient bed, bathing or treatment area, clean supply storage room, clean laundry and linen storage area, or medication set-up area be equipped with a lens cover or a shatterproof lamp; (7) Ensure that any clothes dryer have a	S 166	A list of all doors will be created and all magnetic locking doors in the facility will be included on the maintenance checklist to test for locked door functionality each quarter by Maintenance Supervisor.	4/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason Merkley | TITLE: President & CEO | (X6) DATE: 4/4/2025

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S 166	Continued From page 1 galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 281A; and (8) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review, the provider failed to document and maintain a preventive maintenance program for testing and documenting magnetically locked door functional characteristics (entire building). Findings include: 1. Observation on 3/3/25 beginning at 9:00 a.m. revealed numerous sets of magnetically locked cross-corridor doors that were installed in many locations throughout the building. The doors did not have any identifying labeling (such as numerical) to easily track and document maintenance events. 2. Interview with the maintenance supervisor at the times of observations revealed some magnetically locked doors released upon activation of the fire-alarm system. He added he wasn't sure what released lockdown doors. He stated none of the doors had marking or labeling features to track maintenance or testing events. He stated the only known testing for some of the doors (including lockdown or OB unit) was facility fire drills. 3. Record review on 3/3/25 at 1:30 p.m. of the facility reports did not indicate if magnetically locked doors met the requirements or exceptions for their various installations and use.	S 166		

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