STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431316	A. BUILDING _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL	111 W 10TH AVE POST OFFICE BOX 420 REDFIELD, SD 57469

(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 485.605-485.645, requirements for Critical Access Hospitals (CAH) and Long Term Care Services ("swing bed"), was conducted from 5/19/25 through 5/22/25. Community Memorial Hospital - CAH was found not in compliance with the following requirement: C888, C914, C1049, C1208, and C1620.	C 000		
C 888	EMERGENCY AND SUPPLIES CFR(s): 485.618(b)(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters. This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Outdated patient care supplies were not available and ready for patient use in three of three crash carts, one of one pediatric airway cart, and one of two ambulances. *Outdated patient care supplies were not available and ready for patient use in three of three emergency treatment rooms, one cardiac rehab room, one of one medication rooms, and one of one nurse aide storerooms. Findings include: 1. Observation on 5/19/25 at 2:30 p.m. in emergency department (ED) room 1 revealed: *One crash cart, one pediatric airway cart, and three large cabinets containing patient care	C 888	1. Outdated supplies were found in multiple areas of the hospital and in the ambulances. This could impact any patients that require the use of medical supplies. Policy 18351284 titled Inventory and/or Removal of Dated Medical Stock has been developed and will be sent to nursing staff, CSR staff, and department directors. Acknowledgement of review for the staff listed above will be 06/30/2025. 2. Nursing and pharmacy staff will be responsible for managing crash carts and pyxis supplies. CSR will be responsible for stocking and maintaining all other medical supplies. EMS staff will monitor boxes as brought to the hospital for restocking. EMS staff will report to EMS director when ET tubes are needed to be reordered. A monthly record will be kept in CSR to ensure all checks are completed on time.Nursing will maintain their monthly records on the crash carts and at the nurse's station. EMS will maintain monthly records for their medication boxes. continued on next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Sjurseth | TITLE: CEO | (X6) DATE: 06/13/2025

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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C 888	Continued From page 1 supplies. *Outdated supplies included: -Three intravenous (IV) start kits with expiration dates of 11/30/22 and 3/31/25. -Multiple gauge needles with expiration dates ranging from 2022 through 2024. -One fiberoptic laryngoscope with an expiration date of 7/31/24. -One foley catheter kit with an expiration date of 8/2020. -Endotracheal kits containing laryngoscope blades with expiration dates ranging from 2019 through 2024. -One oxygen saturation probe with an expiration date of 2024. -Multiple three milliliters (ml) syringes with an expiration date of 3/23. -One lumbar puncture tray with an expiration date of 9/30/24. -One lumen central venous catheter kit with an expiration date of 5/31/24. -One quicktrach kit with an expiration date of 10/21/23. -Three pairs of #6 latex gloves with an expiration date of 8/31/23. -Two pairs of #6 ½ latex gloves with an expiration date of 4/30/24. -Two Yankauer suction devices with expiration dates of 10/24 and 1/28/23. -Two pediatric I-gel airways with expiration dates of 6/23 and 10/23. -19 huggable electrodes with an expiration date of 6/24. Interview on 5/19/25 at 2:45 p.m. with registered nurse (RN) A and RN B revealed: *Nurses had not checked the crash carts, pediatric airway cart, or supply cabinets for expired supplies.	C 888	3. What: 100% compliance on routine checks on all medical products stored in nursing areas and ambulances. Who: Nursing - crash carts and pyxis. CSR staff will check all other medical products in nursing areas. EMS staff will check supplies in medication boxes for ambulances. When: Monthly. How. Checklists. DON or designee, CSR staff, and EMS director will maintain monthly logs. These logs will be reported to the CEO for 6 months, and then departments will monitor for an additional 6 months. POS will be added to the QAPI qualtiy projects, and CEO will report quarterly QAPI results to the Hospital Board of Directors. 4. Anticipated correction date: 06/30/2025	

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C 888	Continued From page 2	C 888		

*Confirmed the supply chain departments were responsible for checking the supplies for items
*RNs A and B confirmed they had never been told to check for outdates in the crash carts, pediatric cart, or cabinets in the ED rooms.
*RN A had thought the supply chain staff were checking for outdated supplies monthly.

2. Observation on 5/19/25 at 3:15 p.m. in the ED triage room revealed outdated patient care supplies. Those supplies included:
*Two #18 gauge (G) IV start needles that expired on 5/31/24.
*One staple removal kit that expired on 4/30/25.
*One chest tube tray that expired on 9/30/23.
*Six huggable electrodes that expired on 6/24.
*Multiple gauge needles located on a baby warmer that expired in 2022.

3. Observation and interview on 5/19/25 at 3:40 p.m. in the medication room with RNs A and B revealed:
*Outdated supplies that included:
-Three #20 G IV needles that expired on 7/31/23.
-Two #18 G IV needles that expired on 12/31/24.
-Four statlock IV device kits with expiration dates of 1/23 and 6/24.
*RNs A and B confirmed nurses had been restocking the supplies in the medication room, but had been unaware of a process for checking for outdated supplies.

4. Observation and interview on 5/19/25 at 4:12 p.m. in ER room 2 with RNs A and B revealed:
*One crash cart containing supplies with expiration dates ranging from 2022 through 2024 included:
-Three IV start kits.
-Four #20 G IV needles.

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C 888	Continued From page 3 -Four #18 G IV needles. -Multiple sterile gloves. -One bougie dilatator. -One I-gel airway. *RNs A and B confirmed the supplies had outdated and should have been discarded. *RN A stated, "I believe there is a miscommunication between nursing and central supply on who is responsible for checking outdates [expiration dates] on patient supplies." 5. Interview on 5/20/25 at 9:15 a.m. with manager of materials management D revealed: *The provider had been following their policy for event-related shelf life and sterile storage of supplies. -She had thought it was acceptable to go six months to a year past the expiration date for supplies if their policy supported that practice. -She had been unaware in that had not applied to patient care items supplied by manufacturing companies. *She agreed expiration dates on patient care supplies set forth by the manufacturer needed to be followed and expired supplies needed to be discarded appropriately. *She confirmed both central supply staff and nurses should have been checking for product expiration dates on the nursing units as outlined in the provider's policy. -Central supply staff had been checking for outdated supplies monthly and when restocking supplies. *She confirmed nurses were supposed to be checking expired supplies in the crash carts as outlined in the provider's crash cart policy. *She confirmed the supplies found throughout the ED rooms and crash carts had expired and should have been removed.	C 888		

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C 888	Continued From page 4 6. Observation and interview on 5/20/25 at 10:15 a.m. in two of two ambulances with director of ambulance E revealed: *Outdated supplies in one ambulance included: -Three #22 G IV needles with an expiration date of 2024. -Four #20 G IV needles with an expiration date of 4/26/25. -Eight endotracheal tubes with an expiration date of 2024. *He confirmed he had been responsible for checking for outdated supplies monthly. *He confirmed the intubation supplies had been purchased as a kit and had not been checked for expiration dates. *He agreed staff should have been checking all patient care supplies for expiration monthly. 7. Observation on 5/20/25 at 1:45 p.m. in the nurse aide storeroom located by the nurses' station revealed: *Outdated supplies included: -Five staple removal trays with an expiration date of 9/25/23. -Two staple removal trays with an expiration date of 3/4/25. 8. Observation and interview on 5/21/25 at 10:45 a.m. in the cardiac rehabilitation room with RN K revealed: *In the crash cart drawer there were three sealed packages of five electrodes each that expired on 11/12/23. *She was not sure who monitored the crash cart for expired supplies. *She agreed there should be a checklist for the supplies in the crash cart to ensure that nothing had expired.	C 888		

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C 888	Continued From page 5 *She confirmed the supplies should have been removed from the cart and replaced. 9. Interview on 5/21/25 at 10:00 a.m. with director of nursing (DON) C revealed she: *Had thought the supply chain staff had been responsible for checking the crash carts for outdated supplies. *Stated, "This is on me. I did not communicate with nursing staff that they were responsible for checking the crash carts for outdated supplies." *Confirmed staff should have been discarding supplies that had expired as dated on the packaging per the manufacturer. *Would have expected nurses to check for expired supplies prior to patient use. *Would have expected staff to ensure outdated supplies were removed prior to restocking. Review of the provider's January 2023 Emergency Crash Cart Protocol and Defibrillator Checks policy revealed: *"All crash carts will be checked monthly by the Pharmacy Department to check medications for outdates. *Nursing will check for outdated supplies. *Central supply will be notified of any nonpharmacy outdates for replacement purposes. *After each use, the supplies must be checked and replenished. *Nursing should replenish supplies after wiping off the crash cart." Review of the provider's April 2024 Event-Related Shelf Life & Sterile Storage policy revealed: *"Sterility of items will be event-related, but some commercially processed items will also be date-related.	C 888		

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C 888	Continued From page 6 *These dates are monitored by CSR and the department and the items discarded when the date is reached. *An hourglass is sometimes used in manufacturing to mean expiration." Review of the provider's March 2025 Sterile Supplies policy revealed: *"It is the responsibility of the Central Supply Services and nursing when available in down time to check routinely for outdated supplies in the nursing units, exam rooms, and [the] emergency room. *Central Supply supplies are monitored for outdated supplies every month, those which are outdated or soon to be outdated before next check will be re-processed or destroyed. *In a department where CSR does not check outdates, it will be the responsibility of the Department Head to monitor outdates." Review of the provider's March 2025 Supplies (Ordering/Stocking) policy revealed: *"Nursing Unit Supplies: -CSR and Nursing when able is responsible to check daily for adequate supplies in ER, Triage, ICU, Exam Room and Nurses Aid Storeroom. -Product outdates will be checked monthly and removed as appropriate."	C 888		
C 914	MAINTENANCE CFR(s): 485.623(b) , 485.623(b)(1) The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;	C 914		

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C 914	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview, equipment logs review, policy review, and manufacturer's instruction for use (IFU) review, the provider failed to ensure: *The temperature of one of one fluid warmer machines located in the medication room had been monitored daily. *One of one Medivators Advantage Plus endoscope reprocessor machine's (disinfects endoscopes) water and air filters had been changed every six months per the manufacturer's IFU. Findings include: 1. Observation and interview on 5/19/25 at 3:40 p.m. with registered nurse A in the medication room revealed: *One fluid warmer contained three bags of lactated ringers solution. *No temperature readings had been recorded for May 4, 10, 11, 17, and 18 on the temperature log. *She stated the pharmacy staff was responsible for documenting the temperatures of the fluid warmer. *She had never been told to record the temperatures on the fluid warmer when pharmacy staff were not on-site. Interview on 5/20/25 at 3:10 p.m. with pharmacist coordinator J and pharmacy technician O revealed: *Confirmed pharmacy staff were responsible for monitoring and documenting the temperatures of the fluid warmers when pharmacy staff were on-site. *Pharmacy technician O stated, "Depends on who is working if the nurses will monitor the warmer when we are not here."	C 914	1. The fluid warmer in the nursing department did not have daily temperatures recorded at the time of the survey. Any patients receiving warmed fluids could be impacted by incorrect temps if not checked and recorded by staff. 2. The fluid warmer has been removed from the department as of 06/13/2025. Going forward, staff will utilize the 3M Ranger fluid warmers located in the ERs on a per patient basis. 3. What: Daily temperature checks for fluid warmer. Who: Pharmacy or nursing staff. When: Daily while in use. How: Pharmacy or nursing staff will monitor daily temperature checks for fluid warmer. DON or designee will monitor results weekly and report monthly checklist to CEO. 4. Anticipated correction date: 06/30/2025	

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C 914	Continued From page 8 *Pharmacist coordinator J confirmed there had not been formal communication to the nursing staff about documenting the temperatures of the fluid warmers when pharmacy staff were unavailable. *Both agreed the temperatures of the fluid warmer should have been monitored and documented daily. Interview on 5/21/25 at 10:00 a.m. with director of nursing C revealed: *The fluid warmer temperatures had been monitored by pharmacy staff. *She was unaware the fluid warmers needed to be checked on the weekends or when the pharmacy staff had been unavailable. *She stated nursing staff could have assisted in documenting fluid warmer temperatures daily. Review of the provider's May 2025 Bulk IV Fluid Warmers policy revealed: *"All bulk IV bag fluid warmers are to have a visible thermometer. *The temperature of the warmer is monitored daily by pharmacy and/or nursing staff if pharmacy is unavailable." 2. Observation and interview on 5/20/25 at 8:35 a.m. with manager of materials management D in the endoscope reprocessing decontamination room revealed: *Three air filters on the wall had dates listed on each filter that read 6/24/24. *She -Confirmed maintenance was responsible for documenting the water and air filter logs. -Did not have the maintenance log for the filter changes in the decontamination room to reference.	C 914	1. Endoscope reprocessing tower was found to have outdated air filters. The air and water filters should be replaced every 6 months. Improper maintenance could impact scope cleaning. 2. Maintenance will monitor and replace filters every 6 months per MIFU. 3. What: Routine air and water filter replacements for endoscope reprocessing tower per MIFU guidelines. Who: Maintenance department. When: Every 6 months as recommended. How: Checklists. Will also report to CEO for 1 year. POC of will be added to QAPI, and CEO will report results quarterly to the Hospital Board of Directors. 4. Anticipated correction date: 06/30/2025	

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C 914	Continued From page 9 -Was unsure if maintenance kept a separate log of the filter change dates. -Would reach out to the director of maintenance to the confirm air and water filter changes of the Medivators Advantage Plus endoscope reprocessor. Interview on 5/20/25 at 1:30 p.m. with manager of materials management D of the reprocessor's air and water filter logs revealed: *Documentation of the air filter changes had been completed in July 2024 by maintenance. -The reprocessor's left and right air filters should have been changed every six months per the manufacturer's IFU. *Documentation of the water filter changes had been completed in July 2024. -The water filters (1 micron, 0.4 micron, and 0.1 micron) should have been changed every six months per the manufacturer's IFU. *She was unaware of when the manufacturer had changed the time frame for the air and water filters, as she thought it had been every year. Interview on 5/20/25 at 1:55 p.m. with director of plant operations F revealed: *He was unaware the reprocessor's air and water filters needed to be changed every six months per the manufacturer's IFU. *He confirmed maintenance had been changing the filters yearly, and that was last completed in June 2024. *He agreed the air and water filters should have been changed every six months according to the manufacturer's IFU. Review of the Medivators 2020 Advantage Plus Endoscope Reprocessor Manufacturer's IFU revealed:	C 914		

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C 914	Continued From page 10 *"The Advantage Plus Reprocessor has four air filters. Each filter should be replaced every 6 months. *Water filters should be replaced at a minimum of every 6 months for the 1.0 micron and 0.4 micron filters. *0.1 micron minimum replacement schedule is 6 months."	C 914		
C1049	NURSING SERVICES CFR(s): 485.635(d)(3) §485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws. This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two syringes that had contained the medication Cimzia (medication used to treat inflammatory conditions) had been labeled with the medication name, strength, expiration date or time for one of one patient (28). Finding include: 1. Observation on 5/20/25 at 2:23 p.m. in treatment room 155 with registered nurse (RN) H and patient 28 revealed: *RN H: -Entered the room with two unlabeled syringes containing a clear solution that had been prepared in the medication room. -Had two empty vials of Cimzia 200 milligrams (mg)/1 milliliters (ml).	C1049		

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C1049	Continued From page 11 -Laid the syringes down on the bedside table. -Verified the identity of patient 28. -Scanned each vial of Cimzia into the computerized medication record. -Administered each of the unlabeled syringes of solution separately into patient 28's abdomen. Interview on 5/20/25 at 2:30 p.m. with RN H and RN G revealed: *Medications were labeled only if multiple different medications were drawn up at the same time. *Their practice had not been to label syringes if drawing up a single medication, or if drawing up the same medication into multiple syringes. *Confirmed medications were drawn up in the medication room and walked to the patient's room for administration. *RN H and RN G confirmed they had not been aware a single medication or the same medication drawn up into multiple syringes needed to be labeled. Interview on 5/21/25 at 10:00 a.m. with director of nursing C revealed: *All medications required a label for proper identification. *Syringes containing medication should have been labeled with the medication name, strength, expiration date and time per the provider's policy. Review of the provider's June 2024 Medication Administration policy revealed: *"Medications are prepared, administered, labeled and recorded by personnel licensed to administer medications. *All medications that is not immediately administered must be labeled. Any medications that are transferred from the original packaging to	C1049	1. All nursing staff will be required to label any medications they draw up per policy #16026796 Medication Administration. This ensures that the "5 Rights" are followed for each patient. Failure to label medications could result in a medication error that could impact a patient. 2. Nursing staff drawing up medications will use labels for each syringe. The labeling requirement will be reviewed during the annual pharmacy education due by May 31 of each year. Nursing staff will be assigned the policy for review during annual education. Education requirements will be montiored on Policy Stat, or by a signed acknowledgement of staff. 3. What: Labeling medications. Who: DON or designee. When: Visual audits performed weekly for 6 months until 90% compliance for monthly QAPI quality project, and QAPI to determine additional auditing after. How: Weekly visual audits will be conducted by DON or designee, and will report monhtly to CEO for 6 months. CEO will report quarterly QAPI results to the Hospital Board of Directors. 4. Anticipated correction date: 06/30/2025	

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COMMUNITY MEMORIAL HOSPITAL	111 W 10TH AVE POST OFFICE BOX 420 REDFIELD, SD 57469

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C1049	Continued From page 12 another container must be labeled with: -Medication or solution name, -Strength, -Amount of medication (if not apparent from the container), -Diluent name and volume, -Expiration date or time. *Immediately discard any mislabeled products."	C1049		
C1208	INFECTION PREVENT SURVEIL & CONTROL OF HAIs CFR(s): 485.640(a)(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and that the program also addresses any infection control issues identified by public health authorities; and This STANDARD is not met as evidenced by: Based on observation, interview, policy review, and manufacturer's instructions for use (IFU) review, the provider failed follow standard infection prevention practices by not having ensured one of one observed glucometer had been cleaned and disinfected properly prior to patient use. Findings include: 1. Observation and interview on 5/19/25 at 4:00 p.m. with registered nurse (RN) A and RN B revealed: *One glucometer that was docked and ready for patient use had a visible blood smear on top of the machine. *RNs A and B confirmed there was visible blood on the glucometer and it had not been cleaned properly prior to it being placed in the docking	C1208		

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C1208	Continued From page 13 station. *RN A confirmed the procedure for cleaning the glucometer was to use a PDI disinfectant wipe after each patient use. *RN A removed the blood glucometer and used a PDI wipe to disinfect it. Interview on 5/21/25 at 10:00 a.m. with director of nursing (DON) C revealed: *Glucometer machines should have been cleaned with a PDI disinfectant wipe between each patient use. *Staff should have inspected the glucometer prior to placing it in the docking station to ensure it was appropriately cleaned. Review of the provider's December 2024 NOVA Biomedical StatStrip Glucometer Hospital Meter policy revealed: *"Cleaning the meter: -The meter should never be immersed in any cleaning agent. -Always apply the cleaning agent to a soft cloth to wipe the meter surface. -The cloth should be damp NOT dripping. -Make sure that no solution is allowed to enter the strip port or the docking port." Review of the provider's November 2024 Equipment Cleaning policy revealed: *"For the safety and comfort of patients, all reusable "noncritical" patient care items will be cleaned, disinfected, and maintained in a safe manner between patient use. *Patient equipment will be disinfected immediately following patient use when the item has been contaminated with blood or other potentially infectious material (OPIM) or is visibly soiled.	C1208	1. Upon inspection of the glucometer at the nurse's station, dried blood was found on the machine. Disinfection is required after each patient use to ensure proper infection control practices are being followed for patient safety. 2. A cleaning check off will be added to the daily QC checks for glucose monitor. Education will be provided to nursing staff on cleaning requirments after every patient glucometer is used on. 3. What: Daily glucometer QC and cleaning will be conducted by nursing staff. Who: DON or designee. When: Daily. How: DON or desginee will report monthly QC reports to CEO for 6 months, and DON or designee will monitor until 100% compliance is achieved. Monthly checklist will be added to QAPI quality project. CEO will report quarterly QAPI to Hospital Board of Directors. 4. Anticipated correction date: 06/30/2025	

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C1208	Continued From page 14 *All reusable patient care equipment removed from a patient room/procedure room is disinfected before use or another patient. *Disinfection recommendations: -Between each patient use (anything that touches a patient)-Some examples: -Glucose Meters." 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."	C1208		
C1620	COMP ASSESSMENT, CARE PLAN & DISCHARGE CFR(s): 485.645(d)(5) §485.645(d)(5) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to	C1620		

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C1620	Continued From page 15 use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). " §483.20(b) Comprehensive assessments- (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition.	C1620		

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C1620	Continued From page 16 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. (2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) (ii) Within 14 calendar days after the facility	C1620		

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C1620	Continued From page 17 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) Not less often than once every 12 months. " §483.21(b) Comprehensive care plans. (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	C1620		

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C1620	Continued From page 18 (i) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (ii) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	C1620		

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C1620	Continued From page 19 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. (ii) Be provided by qualified persons in accordance with each resident's written plan of care. (iii) Be culturally-competent and trauma-informed. " §483.21(c)(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is	C1620		

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C1620	Continued From page 20 not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This STANDARD is not met as evidenced by: Based on record review, social service consultant reports review, interview, and policy review, the provider failed to ensure Case Manager/Social Services (CM/SS) Assessments (used to develop individualized discharge plans) were completed for four of four sampled swingbed patients (7, 8, 9, and 10). Findings include:	C1620		

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C1620	Continued From page 21 1. Review of patients 7, 8, 9, and 10's electronic medical records (EMR) revealed: *There was no documentation to support a CM/SS Assessment had been completed for patients 7, 8, 9, and 10. -Information from the CM/SS Assessment was used to develop an individualized discharge plan for each patient. *That assessment would have included discharge-related information such as: -If the patient had a primary care physician. -The patient's social/living circumstances. -Their post-discharge goal/treatment preferences. -Their anticipated discharge location. -The supports/resources the patient used prior to admission and the supports/resources the patient needed after discharge. -Transportation needs. -Durable medical equipment (DME) the patient used prior to admission and the DME the patient needed after discharge. -The patient's ability/inability to pay for prescribed medications. -Their insurance information. Interview on 5/20/25 at 3:38 p.m. with director of nursing (DON) C regarding the completion of a CM/SS Assessment revealed: *She stated licensed clinical social worker (LCSW) consultant P had informed her an initial CM/SS Assessment did not need to be completed. -Other social service documentation including discharge planning notes and care conference notes were completed "at least weekly." Telephone interview on 5/21/25 at 11:00 a.m. with LCSW consultant P revealed: *He consulted with DON C by telephone and he	C1620		

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C1620	Continued From page 22 reviewed patients' EMRs off-site. *His consultant reports were forwarded to chief executive officer (CEO) I and DON C upon completion. *A part of his consultation was the review of sampled swing bed patients' EMRs for expected social service documentation. -That included completion of a CM/SS Assessment and CM/SS Discharge Planning notes. Continued interview and review of LCSW consultant P's 6/12/24, 9/18/24, 12/10/24, and 3/20/25 consultant reports regarding the above social service documentation revealed: *CM/SS Discharge Planning notes were completed for the residents he had reviewed, but there was no documentation to support a CM/SS Assessments had been completed for those residents. -The 6/12/24 consultation documentation indicated: "I think it would be beneficial for staff to complete the Social Service Assessment Swing Bed form [a form comparable to the CM/SS Assessment] on each admission." *The 9/18/24 consultation documentation indicated: "I did not find use of either the CM/SS Assessment [or the] Social Service Assessment Swing bed forms. I still think it would be beneficial for staff to at least complete the Social Service Assessment Swing bed Form on each admission." *The 12/10/24 consultation documentation indicated: "I did not find use of the Social Service Assessment Swing Bed form." "...I still think it would be beneficial for staff to complete this brief assessment with each swingbed admission." *The 3/20/25 consultation documentation indicated: "Some (but not all) charts contained	C1620	1. CM/SS assessments will occur within 24 hours of admission for 100% of patients. Failure to complete the assessment could limit the necessary resources used and/or needed by the patient at the time of discharge. All admitted patients have the potential to be impacted. 2. CM/SS monitoring has been added to the utilization review chart checks. Staff education will be communicated to all nursing staff by DON by 6/30/25. 3. What: Monitoring for 100% completion of CM/SS assessments. Who: UR, DON or designee. When: Monthly for 6 months, reporting results to CEO. Then DON or designee will continue to monitor for additional 6 months. POC will be added to the QAPI plan. CEO will report quarterly QAPI plan to the Hospital Board of Directors. Anticipated correction date: 06/30/2025.	

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C1620	Continued From page 23 CM/SS Assessment entry." "My recommendation is for staff to complete this assessment for each swing bed admission." Interview on 5/21/25 at 1:30 p.m. with CEO I regarding LCSW consultant P's above quarterly consultation reports revealed: *She confirmed DON C was LCSW consultant P's primary contact for social service consultations. It was DON C's responsibility to have reviewed the consultation reports and addressed the consultant's recommendations with the staff and/or consultant as needed. *She had not known LCSW consultant P had repeatedly identified the same concerns regarding social service documentation. That pattern was indicative of a system failure that should have been brought to her attention for remediation. *Information obtained from the CM/SS Initial Discharge Assessment was used to direct a patient's discharge plan. *The CM/SS Initial Discharge Assessment referred to in the provider's policies was the same assessment LCSW consultant P had referred to as the CM/SS Assessment. -The expectations for completion of the CM/SS Initial Discharge Assessment had not been followed according to the provider's policy. Review of the provider's revised January 2020 Discharge Planning-Acute & Swing Bed policy revealed: *Patient Assessment: -"The admitting nurse will complete the CM/SS Initial Discharge Assessment." Review of the provider's revised May 2021 Swingbed Utilization Review Plan policy revealed:	C1620		

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C1620	Continued From page 24 *V. Procedure for Discharge Planning: -"A. Planning is initiated on the CM/SS Initial Discharge Assessment on admission."	C1620	Type text here	

South Dakota Department of Health

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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 5/19/25 through 5/22/25. Community Memorial Hospital was found not in compliance with the following requirements: S0157 and S0221.	S 000		
S 157	44:75:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to supply electrically powered exhaust ventilation to the outside for one of one biohazard storage room. Findings include: 1. Observation and interview on 5/22/25 at 11:20 a.m. in the biohazard storage room with maintenance assistant Q revealed: *An absence of electrically powered exhaust ventilation. *The room was used to store biohazard waste. *Maintenance assistant Q confirmed the biohazard storage room was not equipped with an electrically powered exhaust ventilation. *The only ventilation for the room was passive ventilation through holes in the walls leading into the crawl space and the maintenance room.	S 157	1. During inspection of the biohazard storage room, there was no powered exhaust ventilation, only passive ventilation. Failure to have correct ventilation could cause airflow issues within the storage room. 2. Maintenance will add powered exhaust ventilation to the biohazard storage room by creating a new venting path from the existing powered ventilation ducts. This path will be tied into an existing duct that travels through a storage room and non-patient bathroom and will not travel through patent areas. Maintenance will seal closed the passive ventiliation openings. The airflow of the powered ventilation will be montiored by maintenance after it is in place. 3.What: add powered ventilation to bioharzard storage room. Who: Maintenance department. When: After installation, maintenance will monitor for correct air flow monthly. How: Monthly visual check. 4. Anticipated date of correction: 11/22/2025 Due to construction requirments, additional time for completion is required. A formal request for an extension will be sent to the DOH.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Sjurseth	CEO	06/13/2025

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(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 221	Continued From page 1	S 221		
S 221	44:75:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. These programs must be completed by all healthcare personel within thirty days of hire and annually thereafter, and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints and seclusion; (6) Patient rights; (7) Confidentiality of patient information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of patients with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of patients; (11) Advanced directives; and (12) Abuse and neglect. Any personnel whom the facility determines will have no contact with patients are exempt from training required by subdivisions (5), (8), (9), (10), (11), and (12) of this section. The facility shall provide additional personnel education based on the facility's identified needs. The facility shall make available current professional and technical reference books and periodicals for personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review and interview, the provider failed to ensure annual education for two	S 221		

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
	10560S	A. BUILDING: _____ B. WING _____	05/22/2025

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S 221	Continued From page 2 of six sampled employees (L and M) was completed. Findings include: 1. Review of registered nurse (RN) L's employee file revealed: *She was hired on 1/5/23. *There was no record she had completed any of the required annual training in 2024 or 2025. *Those missing training topics were: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints and seclusion. -Patient rights. -Confidentiality of patient information. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. -Care of patients with unique needs. -Dining assistance, nutritional risks, and hydration needs of patients. -Advanced directives. -Abuse and neglect. 2. Review of paramedic M's employee file revealed: *He was hired on 12/7/22. *There was no record of him completing any of the required annual training in 2024 or 2025. *Those missing training topics were: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints and seclusion. -Patient rights. -Confidentiality of patient information. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms.	S 221	1. Upon review of several employee files, it was found that different education components were not documented as complete. Per policy Required Annual Education Topics for All Employees #17442420, annual education is required for all employees. Failure of employees to complete assigments puts the facility out of compliance for education requirements. 2. Department directors will be responsbile for monitoring education requirements for their staff. The CEO will also monitor monthly facility reports for a year. Employees that are delinquent with education requirements will be subject to performace improvement plans. 3. What: Montioring of education completion for all staff. Who: Directors, CEO will monitor facility. When:Monthly. How: Directors will monitor through HealthStreams, CEO will monitor reports from Healthstreams and add the POC to the QAPI quality plan. CEO will report quarterly QAPI to Hospital Board of Directors. 4. Anticipated completion date: 06/30/2025	

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S 221	Continued From page 3 -Care of patients with unique needs. -Dining assistance, nutritional risks, and hydration needs of patients. -Advanced directives. -Abuse and neglect. 3. Interview on 5/20/25 at 2:15 p.m. with human resources partner N revealed: *The department heads were responsible for making sure the staff in their department completed the training. *She could not find where RN L was assigned the annual training for 2024. *She confirmed the required annual training was not completed by RN L and paramedic M. 4. Interview on 5/21/25 at 1:40 p.m. with chief executive officer (CEO) I revealed: *All staff were assigned the required annual training. *Her expectation was that all staff would complete the training as assigned. 5. Review of the provider's 1/2024 revised Required Annual Education Topics for All Employees policy revealed: *"Assign required mandatory education during the months of January-December with a consistent due date set for all employees." *"Annual mandatory education would continue to be assigned with a required due date." *"Staff that has not completed their mandatory annual education by the assigned due date will be considered past due." *"Each Department Head is responsible for ensuring all education is completed in a timely manner."	S 221		

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	431316	A. BUILDING **01 - BUILDING 01** B. WING _____	**05/22/2025**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 5/22/25 for compliance with 42CFR 485.623(d)(1), requirements for critical access hospitals (and swing bed). Community Memorial Hospital (building 1) was found in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiency identified at K131, K222, K223, K225, K321, K363, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 131	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of	K 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Sjurseth — TITLE: CEO — (X6) DATE: 06/13/2025

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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K 131	Continued From page 1 patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the positive latching feature of the door located in the two-hour separation between the clinic and the hospital during the business hours from 8:00 a.m. to 5:00 p.m. Findings include: 1. Observation, testing, and interview on 5/22/2025 at 2:45 p.mm with maintenance assistant Q of the two-hour separation between the hospital and the clinic revealed: *The ninety-minute fire-rated door between the clinic and the hospital was equipped with an electronic strike door latch. *During the business hours from 8:00 a.m. to 5:00 p.m. the door was programmed to release the electronic strike. *When the electronic strike was released the latching feature of the door was disabled. *Testing of the latching feature revealed the door could be pulled or pushed open without the need to turn the door handle proving the door was not positive latching. *It was unknow if the electronic strike would latch upon initiation of the fire alarm system. Follow up clarification regarding the latching of the electronic strike during initiation of the fire alarm system was requested by e-mail on 5/29/25 at 3:27 p.m. Director of maintenance R responded to request for clarification on 5/30/25 at 4:24 p.m. and verified the electronic strike would not latch during the initiation of the fire alarm system and	K 131	1. Door needs to latch during active fire alarm. If the door does not latch it will not create a proper barrier in the event of a fire. This could potenially impact patients in the building. 2. Maintenance will contact the door contractor to interface the door with the fire alarm system. This change will allow the door to latch closed during a fire alarm. 3. What: Maintenance will coordinate with the door contractor to make appropriate modifications to the door. Who: Maintenance director. When: Monthly checks once door has been modified. How: Monthly visual checklist will be reported to CEO for 6 months, and then maintenance team will monitor ongoing. The POC will be added to QAPI plan, and CEO will report quarterly findings to the Hospital Board of Directors. 4. Anticipated correction date: 11/22/2025 *a formal request for an extension will be submitted to the DOH.	

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K 131	Continued From page 2 confirmed the door was not positive latching.	K 131		
K 222	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		

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K 222	Continued From page 3 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider installed a lock on an egress/horizontal exit door in one randomly observed exit access corridor between the hospital and the clinic. Findings include: 1. Observation and interview on 5/22/2025 at 2:45 pm with maintenance assistant Q of a door between the hospital and the adjoining clinic, which serves as an egress/horizontal exit door for both occupancies, revealed the door has an electronic strike installed that is normally unlocked during the clinic's hours of operation and is otherwise locked. Testing revealed that the	K 222	1. Door is considered an exit door, but the door is locked after hours. In the event of a fire, the door could potentially be locked, prolonging exit out of the building. 2.Maintenance director will coordinate with door contractor to install an delayed egress mechanism with alarm. 3. What: Add delayed egress mechanism to door. Who: Maintenance depament and door contractor. When: Monthly during fire drills. How: Checklist monitored by maintenance department.CEO will monitor for 6 months, and maintenance will monitor ongoing. POC will be added to QAPI quality plan. CEO will report quarterly findings to Hospital Board of Directors. 4. Anticipated correction date: 11/22/2025 *a formal request for an extension will be submitted to the DOH.	

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K 222	Continued From page 4 door, when locked, stays locked during a fire drill. This is a deficiency as all egress doors and horizontal exit doors are required to be unlocked at all times. Interview with maintenance assistant Q confirmed the finding. He agreed it was a deficiency.	K 222		
K 223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire and/or smoke barrier for three randomly observed door assemblies. Findings include: 1. Observation and interview on 5/22/2025 at 10:20 am with maintenance assistant Q of a door between the laundry and the soiled linen room revealed the door was fitted with a closer but was being held open by a wooden wedge. When the wedge was removed, the door would not close	K 223		

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K 223	Continued From page 5 due to interference with the frame. Also, the door was deconstructing (delaminating). The condition of the door compromises the door assembly's ability to resist the passage of smoke as well as pathogens from the soiled linen room to the laundry. 2. Observation and interview on 5/22/2025 at 2:10 pm with maintenance assistant Q of an egress corridor double door assembly in the business center revealed the doors were unable to latch during testing due to interference with each other at the top interior edges. This compromises the door assembly's ability to resist fire spread and the passage of smoke. 3. Observation and interview on 5/22/2025 at 2:25 pm with maintenance assistant Q of an egress (north) corridor double door assembly near room 180 revealed the south leaf of the door assembly was unable to consistently latch during testing. This compromises the door assembly's ability to resist fire spread and the passage of smoke. Interview with maintenance assistant Q at the time of each observation confirmed the findings. He agreed they would not resist the passage of smoke.	K 223	1. Laundry door (1), business center double doors (2), and north cooridor double doors (3) were found not to latch properly. This could compromise the ability of the door(s) to resist the passage of smoke in the event of a fire. 2. Hinges have been fixed, reworked the closures, and remounted with new hardware. Maintenance will also reposition the door and adjust the closure timing to ensure doors close properly. Maintenance will also repair the delamination with glue. 3. What: Visual checks. Who: Maintenance department. When: Monthly, reported to CEO for 6 months, and then monitored ongoing by maintenance for 1 year. How: Documented on a monthly checklist as part of the QA process for QAPI quality projects.CEO will report quarterly QAPI to Hospital Board of Directors. Anticipated correction date: 07/06/2025	
K 225	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		

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K 225	Continued From page 6 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire and smoke barrier for one of four exit enclosures (stairway 10). Findings include: 1. Observation and interview on 5/22/2025 at 10:30 am with maintenance assistant Q revealed a nonlatching door in the basement level of stairway 10, thus compromising the door assembly's ability to resist fire spread and the passage of smoke. Interview with maintenance assistant Q confirmed the finding. He agreed it would not resist fire spread or the passage of smoke.	K 225	1. A nonlatching door was found during inspection in the basement. The door would not resist the passage of smoke in the event of a fire. 2. The door has been adjusted to shut and latch by maintenance. 3. What: Visual monitoring. Who: Maintenance department. When: Monthly. How: Documented on monthly checklist. Will add POC to QAPI quality project. Monthly reports will be sent to CEO for 6 months, and then maintenance department will monitor ongoing. CEO will report quarterly findings to the Hospital Board of Directors. 4. Anticipated correction date: 07/06/2025	
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		

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K 321	Continued From page 7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider created a hazardous area via the accumulation of combustible items within the air handler 1 room in the basement. The provider failed to protect this hazardous area as required, affecting one of six smoke compartments and an exit corridor. Findings include: 1. Observation and interview on 5/22/2025 at 10:50 am with maintenance assistant Q revealed three groupings of mixed combustibles (e.g., cardboard, plastics, fiberglass, adhesives) being stored under large metal forced-air ducts measuring approximately 5' x 5' in cross-section. The bottom of the ducts were approximately 5' above the floor. The floor space occupied by the three combustibles groupings was approximately 5' x 50', 5' x 25', and 5' x 15' for a total area of approximately 450 square feet. This is larger than the 50 square feet of combustibles maximum for nonhazardous areas. Therefore, this area requires hazardous area protections. The area is sprinklered. However, the combustibles are shielded by the metal ducting immediately above, thus compromising the effectiveness of the	K 321	1. Mixed combustibles were found stored under forced air ducts, exceeding the allowable limit. This can potenially create a fire harzard. 2. Maintenance department will remove items to fit the 50 sq. ft. maximum. Non closing door has been repaired. Door wedge has been removed, and the foam safety protector has been shaved down 1/4". Adjacent fire alarm room compromised smoke partition will be repaired with new sheetrock and mud. Ceiling tiles in exit cooridor near fire alarm door will be replaced. 3. What: Visual monitoring. Who: Maintenance department. When: Monthly. How: Documented on monthly checklist. Findings will be reported to CEO for 6 months, and then maintenance will monitor ongoing. POC will be added to QAPI quality plan, and CEO will report quarterly QAPI to Hospital Board of Directors. 4. Anticipated correction date: **07/06/2025**	

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K 321	Continued From page 8 sprinklers. Sprinklered hazardous areas must have smoke resisting partitions. However, the door to the air handler 1 room (from the fire alarm room) was propped open with a wedge. When tested, the door would not close on its own due to interference with a foam safety protector installed on the corner of a nearby metal duct fitting. The adjacent fire alarm room, into which the smoke from the hazardous area would enter in a fire event, had a compromised smoke resisting partition between it and the lay-in ceiling above the adjacent exit corridor (two rectangular holes in the wall measuring approximately 4" (inches) x 12" serving as pipe and cable conduits and one approximately 2" circular penetration containing a pipe without fire caulking near the fire alarm room ceiling). Random observation of ceiling tiles in the exit corridor lay-in ceiling near the fire alarm room door revealed three instances of broken tiles that would not resist the passage of smoke. Interview with maintenance assistant Q confirmed the above findings.	K 321		
K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431316	A. BUILDING **01 - BUILDING 01** B. WING _____	**05/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL	**111 W 10TH AVE POST OFFICE BOX 420 REDFIELD, SD 57469**

(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 363	Continued From page 9 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain the smoke barrier for one randomly observed patient sleeping room (140). Findings include: 1. Observation and interview on 5/22/2025 at 3:20 pm with maintenance assistant Q revealed a gap at the top of the corridor door assembly for room 140 between the top of the door and the door frame stop (latch side) of approximately 1/4" (one-quarter inch) thus compromising the door assembly's ability to resist the passage of smoke.	K 363	1. Door was found to have a gap near the top. This would not prevent the passage of smoke in the event of a fire. 2.After maintenance looked further into the hinges, they will attempt to readjust the existing hinges. If that doesn't close the gap, maintenance will apply a fire rated weather stripping on door to properly cover the gap. 3. What: Visual monitoring. Who: Maintenance department. When: Monthly. How: Monthly checklist. POC will be added to QAPI quality plan. CEO will monitor for 6 months, and then maintenance department will monitor ongoing. CEO will report quarterly results to the Hospital Board of Directors. 4. Anticipated correction date: 07/06/2025	

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	431316	A. BUILDING **01 - BUILDING 01** B. WING _____	**05/22/2025**

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K 363	Continued From page 10 Interview with maintenance assistant Q confirmed the finding. He agreed it would not resist the passage of smoke.	K 363		
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923	1.Too many O2 canisters were stored with combustible items during survey. This is a potential fire hazard. 2.Maintence has found a different storage room option to house O2 canisters located off the ambulance garage. Canisters will be relocated and visually monitored to ensure the proper amount is being stored and combustibles are stored at the appropriate distance from the canisters. 3. What: Visual monitoring of O2 canisters and combustibles. Who: Maintenance department. When: Monthly. How: Monthly checklist to be reported to CEO for 6 months, and then maintenance will monitor ongoing. POC will be added to QAPI quality plan, and CEO will report QAPI quarterly to Hospital Board of DIrectors. 4. Anticipated correction date: 07/06/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431316	A. BUILDING **01 - BUILDING 01** B. WING _____	**05/22/2025**

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K 923	Continued From page 11 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to protect medical gas storage as required in the oxygen cylinder storage room (sprinklered) affecting one of six smoke compartments. Findings include: 1. Observation and interview on 5/22/2025 at 1:30 pm with maintenance assistant Q revealed 13 full "E" size oxygen cylinders (approximately 312 cubic feet) colocated with a spray can of highly flammable glass cleaner, approximately 14 cardboard boxes and other combustibles within 5 feet of the cylinders, and a key-making machine with a grinding wheel which could generate sparks. Each of these observations represent deficiencies. Interview with maintenance assistant Q confirmed the above findings.	K 923		

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	431316	A. BUILDING **03 - ADMINISTRATION PHYSICAL THERAPY** B. WING _____	**05/22/2025**

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COMMUNITY MEMORIAL HOSPITAL	**111 W 10TH AVE POST OFFICE BOX 420 REDFIELD, SD 57469**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 5/22/25 for compliance with 42CFR 485.623(d)(1), requirements for critical access hospitals (and swing bed). Community Memorial Hospital (building 3) was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Sjurseth

TITLE: CEO

(X6) DATE: 06/13/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431316	A. BUILDING _____ B. WING _____	05/22/2025

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E 000	Initial Comments A recertification survey for compliance with 42 CFR 485 Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospital, was conducted on 5/22/2025. Community Memorial Hospital was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Sjurseth
TITLE: CEO
(X6) DATE: 06/13/2025

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.