STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 9/9/24 through 9/12/24. Mobridge Regional Hospital was found not in compliance with the following requirements: C888, C914, and C1140. Notice: On 9/11/24 at 3:47 p.m. notice of immediate jeopardy was given verbally and in writing to chief executive officer (CEO) A, director of quality assurance C, and radiology supervisor J of the immediate jeopardy related to C1140 when the provider failed to follow the manufacturer's instructions for use for MetriCide OPA Plus solution a high-level disinfectant. On 9/11/24 at 3:55 p.m. chief executive officer A, director of quality assurance C, and radiology supervisor J were asked for an immediate removal plan. On 9/12/247 at 10:35 a.m. CEO A provided their final plan for the removal of the immediate jeopardy. On 9/12/24 at 11:40 a.m. the provider's removal plan was reviewed and accepted by the survey team. On 9/12/24 at 11:41 a.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed.	C 000		

	TITLE	(X6) DATE
John J. Ayoub	CEO	10/02/2024

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
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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	Continued From page 1 Current census was zero.	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, policy review, and manufacturer's instructions for use (IFU) review, the provider failed to ensure: *One of one Lifepak 15 defibrillators located outside the operating room (OR) had been checked daily per the manufacturer's IFU. *Expired supplies were not available for patient use in the OR and obstetrical unit. Findings include: 1. Observation and interview on 9/10/24 at 10:57 a.m. outside of the OR with surgery supervisor E and certified registered nurse anesthetist (CRNA) K revealed: *A Lifepak 15 defibrillator had been plugged into the wall on top of a supply cart. *Surgery supervisor E stated the nurse anesthetists had overseen checking the defibrillator. *CRNA K stated it had been the responsibility of the OR nursing staff to monitor and check the defibrillator. *Surgery supervisor E stated, "I'm not sure who brought this equipment in. There was no in-service provided to staff." *Surgery supervisor E said checking the	C 888	All surgical staff were educated on the usage and daily checking of the Lifepak 15 defibrillator as of 9/11/2024 and yearly thereafter. A log for the Lifepak 15 defibrillator and battery checks was implemented and is uniform to the other defibrillator logs in the facility. The defibrillator will be checked daily during the week by the surgical staff and it was put on the charge nurse checklist to be checked by the charge nurse on the weekends and holidays. The Surgery Supervisor added the checking of the defibrillator to her QA that will be reported monthly to the QAPI committee until the committee advises otherwise.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 888	Continued From page 2 defibrillator and managing supplies had fallen through the cracks over the years. *Surgery supervisor E said there had been no maintenance, or an operator's crash cart checklist completed daily. Observation and interview on 9/10/24 at 11:07 a.m. outside of OR with registered nurse (RN) G revealed: *She had been waiting for maintenance to fix the test load device (a tool that can be used to test the defibrillator's function and performance) to perform the user test. *She had not checked the defibrillator in over two years. *RN G stated, "The defibrillator does still work, we need the test load device to perform the user test." *The test load device used to perform the user test was located within the side pocket of the defibrillator. *The manufacturer's IFU and other related resources for the Lifepak 15 defibrillator had not been unsealed from its original packaging for staff reference. Interview on 9/10/24 at 1:25 p.m. with chief nurse officer (CNO) B revealed: *They did not have a policy for crash carts or defibrillator checks. *She stated, "We would follow the manufacturer's IFU." *She would have expected staff to follow the manufacturer's IFU on the Lifepak 15 defibrillator daily checks. *She confirmed there had been a daily crash cart checklist developed and should have been used by all departments.	C 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 888	Continued From page 3 2. Observation and interview on 9/10/24 at 9:22 a.m. in the central supply room with certified surgery technician (CST) F and surgery supervisor E revealed: *There were 14 expired Alcon intraocular lens implants available for use. *Surgery technician F stated the nurses were responsible to check the implants monthly. *Surgery supervisor E stated supplies were checked monthly and any expired items should have been discarded. Observation and interview on 9/10/24 at 10:57 a.m. outside of the OR with surgery supervisor E revealed: *One pediatric quick combo defibrillator patch that expired on 7/20/24. It was the only one available for use. *She confirmed the defibrillator patches should have been replaced. Observation and interview on 9/10/24 at 1:45 p.m. in the obstetrical unit clean supply room with RN H revealed: *In the delivery cart, two sterile #8 gloves that expired in June 2024. *In the hemorrhage cart, one Bakri postpartum balloon device that expired on 9/1/24. It was the only one available for use. *RN H stated carts and supplies were checked monthly. *She confirmed the supplies should have been removed from the carts. Interview with nurse manager D and purchasing director I on 9/12/24 at 9:20 a.m. revealed: *Nurse manager D confirmed checking for outdated supplies had been done monthly and was the responsibility of everyone.	C 888	The Surgery Department were provided education on checking for and removing expired products from the OR at their staff meeting on 10/02/2024. All expired product was removed from the Surgery Department and the Surgery Supervisor has added checking for expired products to a log to be checked monthly by the surgical staff as of 9/16/2024. The Surgery Supervisor added expired products as a new measure to her QA that will be reported monthly to the QAPI committee until the committee determines otherwise. The nursing staff were provided education on checking for and removing expired products from patient care areas at the nurses meeting on 9/18/2024 and it was also posted on the nurse communication page as of 9/19/2024 for all that could not attend the nurses meeting to review. All expired product was removed from the OB Department and the OB Supervisor has created a log to check the OB department log monthly to ensure that expired products have been checked and removed monthly as of 10/01/2024. The OB Supervisor has added expired products to her QA that will be reported monthly to the QAPI committee until the committee determines otherwise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 888	Continued From page 4 *Purchasing director I confirmed every department was to check for outdated supplies. *Confirmed expired products should have been taken back to purchasing. *Nurse manager D confirmed staff had been educated on the process of checking and handling expired supplies. *Nurse manager D confirmed they did not have a policy on managing expired supplies. 3. Review of the provider's daily crash cart checklist for defibrillator revealed staff should have: *Inspected it's physical condition. *Checked the expiration dates on therapy and electrocardiogram (EKG) pads. *Checked the battery power. *Performed a user test. *Verified a therapy cable check at 200 joules. 4. Review of the manufacturer's 2019 Lifepak 15 Monitor/Defibrillator Operating Instructions for Use (IFU) revealed: *Daily inspection and testing of the Lifepak 15 monitor/defibrillator was recommended. *"Complete operator's checklist daily. -Check quick-combo therapy cable. -Inspect defibrillator. -Check all necessary supplies and accessories are present. *Perform the user test as part of the operator's checklist daily." 5. Review of the obstetrical monthly checklist to restock and check outdates revealed: *The case cart had not been signed off as completed in July 2024 and August 2024. *The equipment room had not been signed off as completed in August 2024.	C 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 888	Continued From page 5 *The supply room had not been signed off as completed in July 2024 and August 2024.	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; This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of two blanket warmers in the operating room (OR) was monitored and recorded in accordance with their policy. Findings include: 1. Observation and interview on 9/10/24 at 11:34 a.m. outside of the OR with registered nurse (RN) G and surgery supervisor E revealed: *A small-sized blanket warmer without a digital or internal thermometer to measure the temperature. *RN G confirmed there had been no device to monitor or record the temperature of the blanket warmer. *RN G had stated there should have been a thermometer placed inside the blanket warmer to measure the temperature. *Surgery supervisor E had stated it had been brought into the facility by a physician who used to work there. *Surgery supervisor E confirmed the blanket warmer's temperatures had never been monitored or recorded on a log and should have been.	C 914	The blanket warmer was removed from the facility on 9/23/2024	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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 914	Continued From page 6 Review of the provider's daily log for the OR revealed there had been no documentation of the temperature of the blanket warmer located outside the OR. Review of the provider's April 2024 policy on Warming Cabinets-Blankets and Solutions revealed: *"Fluids and linens (e.g., blankets) must be stored in a separate warming cabinets or in cabinets with separate compartments that have independent temperature controls. *Blanket-warming cabinets temperatures will not exceed 130 F (54.4 C). *Check and record temperatures of linen and solution cabinets daily during hours of operation. *If the cabinet does not have an electronic recording device, the warming cabinet temperatures will be documented daily during hours of operation by Surgical Staff on a temperature log."	C 914		
C1140	SURGICAL SERVICES CFR(s): 485.639 If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section. This CONDITION is not met as evidenced by: A. Based on observation, interview, review of manufacturer's instructions for use, and policy review, the provider failed to: *Follow the reuse period of not more than 30 days for MetriCide OPA Plus solution used for	C1140	Effective immediately, the solution for cleaning the two endo-cavity ultrasound probes has changed from MetriCide OPA Plus to Revital-Ox RESERT, which will be used to clean both probes after each and every use. The temperature and concentration of the high-level disinfectant will be tested by the radiology technician performing the ultrasound prior to every use and documented on a log, which the Radiology Director will turn into the Quality Director every week for review, and report monthly to the QAPI Committee. When a radiology technician opens a new disinfectant container, it will be clearly labeled with the opening date and the expiration date. The disinfectant, once opened, will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 7 high level disinfection on two of two endocavity (within a body cavity) probes. *Test for sufficient strength of MetriCide OPA Plus solution between uses for high level disinfection on two of two endocavity probes. Findings include: Notice: Notice of immediate jeopardy was given verbally and in writing on 9/11/24 at 3:47 p.m. to chief executive officer (CEO) A, director of quality assurance C, and radiology supervisor J of the immediate jeopardy related to C1140 when the provider failed to follow the manufacturer's instructions for use for MetriCide OPA Plus solution a high-level disinfectant. On 9/11/24 at 3:55 p.m. chief executive officer A, director of quality assurance C, and radiology supervisor J were asked for an immediate removal plan. Removal Plan: "Plan of Correction for C-1140 Noncompliance Effective immediately, the solution for cleaning the two endocavity ultrasound probes has changed from MetriCide OPA Plus to Revital-Ox RESERT, which will be used to clean both probes after each and every use. The temperature and concentration of the high-level disinfectant will be tested by the radiology technician performing the ultrasound prior to every use and documented on a log (see attached), which the Radiology Director will turn into the Quality Director every week for review and reported monthly to the QAPI Committee. When a radiology technician opens a new	C1140	stored per manufacturer's recommendations for up to 90 days, provided the 90 days does not extend past the manufacturer's expiration date on the container. The radiology technician will label the solution in the secondary container upon fill with the fill date and the expiration date. The solution in the secondary solution can be used for a period of up to 21 days, or sooner as dictated by the results of the solution test strip. The applicable guiding policy (Endocavity Probe Cleaning & GUS Instructions) has been updated to reflect these changes and all Radiology Department staff will go through education of the policy and competency training in the steps of high-level disinfection according to the manufacturer's instructions for use by 9/13/2024. The Revital-OX RESERT Solution Test Strips will be clearly labeled by the radiology technician with the open date and expiration date. The test strips expire 180 days after opening, or at the manufacturer's expiration date. All chemicals and supplies will be appropriately disposed of and replaced when expired. New quality measures have been added to the Radiology Department's QAPI plan to ensure that prior to every use of Revital-Ox RESERT, the solution concentration,temperature, and expiration date is checked. If, after 6 months, all steps are being correctly completed on 100% of the patients, the Radiology Director will move from weekly reporting to the Quality Director to monthly reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 8 disinfectant container, it will be clearly labeled with the opening date and the expiration date. The disinfectant, once opened, will be stored per manufacturer's recommendations for up to 90 days, provided the 90 days does not extend past the manufacturer's expiration date on the container. The radiology technician will label the solution in the secondary container upon fill with the fill date and the expiration date. The solution in the secondary solution can be used for a period of up to 21 days, or sooner as dictated by the results of the solution test strip. The applicable guiding policy (Endocavity Probe Cleaning & GUS (disinfection soak stations for general purpose and endocavity probes) Instructions - see attached) has been updated to reflect these changes and all Radiology Department staff will go through education of the policy and competency training in the steps of high-level disinfection according to the manufacturer's instructions for use by 9/13/2024. The Revital-OX RESERT Solution Test Strips will be clearly labeled by the radiology technician with the open date and expiration date. The test strips expire 180 days after opening, or at the manufacturer's expiration date. All chemicals and supplies will be appropriately disposed of and replaced when expired. New quality measures have been added to the Radiology Department's QAPI plan to ensure that prior to every use of Revital-Ox RESERT, the solution concentration, temperature, and expiration date is checked (see attached). If, after 6 months, all steps are being correctly completed on 100% of the patients, the Radiology Director will move from weekly reporting to the Quality	C1140	The Radiology Supervisor has provided the Quality Director with the transrectal and transvaginal probe logs weekly for review. Documentation of the solution temperature, testing strips pass or fail, soaking time, original solution container expiration, secondary solution container expiration, and test strips expiration has been completed on all exams performed after 9/13/2024. The Radiology Department will present the new measures to the QAPI committee at the 10/17/2024 meeting and monthly thereafter. The radiology staff were provided competency training, by the Radiology Supervisor, in the steps of high-level disinfection as of 9/13/2024 and will be provided education yearly.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 9 Director to monthly reporting." On 9/12/247 at 10:35 a.m. CEO A provided their final plan for the removal of the immediate jeopardy. On 9/12/24 at 11:40 a.m. the provider's removal plan was reviewed and accepted by the survey team. On 9/12/24 at 11:41 a.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed. Current census was zero. 1. Observation, interview, and review of the manufacturer's instructions for use on 9/11/24 at 12:15 p.m. with radiology supervisor J revealed: *They used MetriCide OPA Plus solution as a high-level disinfectant for the two endocavity probes. *She thought the reuse period was 75 days for the in-use solution based on the information on the label. *She was not aware of the manufacturer's instructions for use. *She was not aware that the reuse period for MetriCide OPA Plus solution was not to exceed 30 days. *She was not aware that each time the MetriCide OPA Plus solution was used it should have been tested for sufficient strength. *She was not aware the 75 days was for how long the solution was good in an opened bottle. *They did not have test strips for testing MetriCide OPA Plus solution. *They had been using MetriCide OPA Plus solution as a high-level disinfectant for up to 75	C1140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 10 days. *They had been discarding every 30 days up to September of 2023 when they changed and went to 75 days before discarding. Review of the manufacturer's instructions for use for MetriCide OPA Plus revealed: *"The reuse period for MetriCide OPA Plus solution was not to exceed thirty days in manual reprocessing." *"Concentration of MetriCide OPA Plus solution during reuse life must be verified by the MetriCide OPA Plus solution test strip prior to each use to determine that the solution concentration was above the minimum recommended concentration." Review of the providers endocavity probe cleaning and GUS (disinfection soak stations for general purpose and endocavity probes) instructions policy dated June 2019 revealed: *"The disinfectant should be changed according to the disinfectant's recommendations." *The policy did not mention testing of the disinfectant. Interview on 9/12/24 at 10:50 a.m. with radiology supervisor J revealed: *Her and the other four technicians who performed high level disinfection had been trained by the previous radiology supervisor. -She had been trained in 2019. *She had assumed they were trained correctly and was not aware they were not performing high level disinfection according to the manufacturer's instructions for use. B. Based on observation, interview, policy review, and manufacturer's instructions review for use	C1140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 11 (IFU) the provider failed to ensure: *Proper concentration of two of two enzymatic detergents and water had been measured per manufacturer's IFU. *The water temperature of the Empower Multi-enzymatic detergent used for pre-cleaning of surgical instruments and endoscopes had been monitored per manufacturer's IFU. *Staff who performed sterilization and high-level disinfection (HLD) tasks had received education and training. Findings include: 1. Observation and interview on 9/10/24 at 9:43 a.m. in the operating room (OR) decontamination room with certified surgery technician (CST) F revealed: *Two large sinks with a sticker inside each of the sinks that indicated a fill line. *CST F confirmed she would fill the water to the fill line in both sinks and add three pumps of Empower multi-enzymatic detergent to the right side of the sink and three pumps of Virex II 256 enzymatic detergent on the left side of the sink. *She was unsure of how many gallons of water each sink held when filled to the fill line. *She was unsure of the ounces (oz) yielded to one pump of enzymatic detergent. *She confirmed they had not been monitoring the temperature of the water after putting the Empower multi-enzymatic detergent in. *She determined with a one-gallon bucket that each sink held about 10 gallons of water at the fill line. *CST F confirmed staff had not been measuring the concentration of the enzymatic detergents to gallons of water as instructed by the manufacturer's IFU.	C1140	All surgical staff were provided demonstration on Decontam Room Solution Measurements for Virex and Empower solutions on 9/11/2024. Stickers were added to both sinks indicating the 3, 4, 5, and 8 gallon fill line for water. A temperature probe was permanently placed in the sink where Empower is used and provides a digital read to ensure temperature is between 68-104 degrees F. A laminated sign is posted above the sink in the Decontam Room with instructions for use of Virex and Empower solution, indicating the solution to water ratio. A log was created for the surgical staff to check the detergent level, water level, temperature, time, and date with every load as of 9/13/2024. The Surgery Supervisor added this measure to her QA and will report monthly to the QAPI committee until the committee advises otherwise. All surgical technicians will complete education on Immediate Use Sterilization, Steam Sterilizer, Steam Sterilizer Use and Care, High-Level Disinfection, ORE-Pro machine usage, and Overall Sterilization Process by 10/11/2024 and yearly thereafter. The Surgery Supervisor created a competency checklist to be completed on all staff working in the OR that will be completed by 10/11/2024 and yearly thereafter. A quality measure on completing the competency checklist for all surgical staff yearly was added to the monthly QA that the Surgery Supervisor will present monthly to the QAPI committee until the committee advises otherwise.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 12 Interview on 9/11/24 at 11:45 a.m. with surgery supervisor E revealed: *The water fill line in each sink was to be used when cleaning scopes not instruments. *She confirmed staff were not measuring the water temperature of the sink and should have been when using Empower multi-enzymatic detergent. *She confirmed staff had not been measuring the proper concentration of the enzymatic solutions and water per the manufacturer's IFU. Interview on 9/12/24 at 11:05 a.m. with chief nurse officer (CNO) B regarding CST F's education and training revealed: *There was no standard form for education or a competency checklist related to high level disinfection and sterilization competencies for surgical staff documented. *Confirmed CST F received education on 9/29/22 on the Sterrad velocity system (steam sterilizer). *Confirmed she could not locate documentation if CST F had received training for the OER-pro (machine used to process endoscopes). *She would have expected education, training, and competencies to have been completed and documented prior to staff performing the skill. Review of the provider's April 2024 High Level Disinfection policy revealed: *"Follow manufacturer's written instructions for use when preparing and using disinfectant solutions. *Perioperative personnel processing medical devices using HLD for use in the perioperative setting will receive education and compete competency verification activities on the principals and processes of processing medical devices using HLD."	C1140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(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
C1140	Continued From page 13 Review of the provider's April 2024 Sterilization-All Methods policy revealed: *"Items to be sterilized will be cleaned, decontaminated, inspected packaged, sterilized, and stored in a controlled environment and in accordance with the device manufacturer's written instructions for use. *Perioperative personnel who sterilize items for use in the perioperative setting will receive education and complete competency verification activities on the principals and processes pertinent to all methods of sterilization." Review of the 2024 EmPower Multi-enzymatic solution detergent revealed, "Add 1 fl. oz (30 ml) (1 pump yields 1 fl. oz) of concentrate to one gallon of warm water (68 F-104 F)." Review of the 2018 Virex II 265 disinfectant revealed to "Add the product at ½ oz per gallon of water (1:256)."	C1140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING **II - MOBRIDGE REGIONAL HOSPITAL** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	**1401 10TH AVE WEST MOBRIDGE, SD 57601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 9/10/24 for compliance with 42CFR 485.623(d)(1), requirements for critical access hospitals (and swing bed). Mobridge Regional Hospital was found not in compliance. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of deficiencies identified at K211, K293, K345, and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to provide unobstructed paths of egress for two randomly observed exit discharge locations (west patient wing exit discharges). Findings include: 1. Observation on 9/10/24 at 9:30 a.m. revealed the west patient wing north and south exit discharges were approximately 50% overgrown with weeds on both sides of the sidewalks. The weeds on both sides of the sidewalk were extending approximately 25% on each side of the 48 inch wide sidewalks and obstructed the path of	K 211	The overgrowth was removed from the west patient wing north and south exit on 9/12/2024. Maintenance staff will check the west patient wing north and south exit weekly for obstruction and will be documented on a log. The Maintenance Supervisor added the weekly check to his QA that will be presented monthly to the QAPI committee until the committee determines otherwise.	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John J. Ayoub
TITLE: CEO
(X6) DATE: 10/02/2024

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
	431325	A. BUILDING **II - MOBRIDGE REGIONAL HOSPITAL** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	**1401 10TH AVE WEST MOBRIDGE, SD 57601**

(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 211	Continued From page 1 egress. Interview at the time of the observation with the environmental services director confirmed those conditions. He stated the landscaping from recent building construction was not yet completed and was unaware the plant growth was extending over the sidewalks. The deficiency affected 100% of the smoke compartment occupants.	K 211		
K 293	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to install an illuminated exit sign for one random location in the patient wing (north corridor westerly direction). Findings include: 1. Observation on 9/10/24 at 9:00 a.m. revealed the north corridor of the patient wing heading west did not have an illuminated exit sign showing the path of egress in an emergency. Interview with the environmental services director at the time of the observation confirmed that finding. He stated a sign had not been installed since the new building was constructed. The deficiency affected one location required to be provided with a marked and identifiable path of	K 293	Exit signage is displayed in the north corridor of the patient wing heading west as of 9/27/2024 and is tied into Emergency Power. The Maintenance Supervisor and Safety Officer added checking for appropriate exit signage prior to the opening of any new construction areas to their checklist and it will be reported to the Safety Committee.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING **II - MOBRIDGE REGIONAL HOSPITAL** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	**1401 10TH AVE WEST MOBRIDGE, SD 57601**

(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 293	Continued From page 2 egress.	K 293		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire alarm system as required for calendar year 2024 (patient wing smoke detection). Findings include: 1. Observation on 9/10/24 beginning at 9:15 a.m. revealed the smoke detector in the environmental services closet had a plastic cover on the smoke detector. The plastic cover negated the functionality of the smoke detector. Further observation revealed a plastic cover on the smoke detector in the soiled utility room in the south patient wing corridor OB wing and a plastic cover on the smoke detector in the emergency equipment storage room in the south patient wing. Interview with the environmental services director at the time of the observations confirmed those findings. The plastic covers were removed during the survey. Failure to maintain the fire alarm system as required increases the risk of death or injury due	K 345	All covers were removed from the smoke detectors as of 9/11/2024. The Maintenance Supervisor and Safety Officer added checking smoke detectors for coverings prior to the opening of any new construction or renovation areas to their checklist and it will be reported to the Safety Committee. The Safety Officer added checking smoke detectors for coverings on the environmental surveys that are completed by the Department Supervisor and the Safety Officer in each department twice a year and will be reported to the Safety Committee.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING **II - MOBRIDGE REGIONAL HOSPITAL** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	**1401 10TH AVE WEST MOBRIDGE, SD 57601**

(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 345	Continued From page 3 to fire. The deficiency had the potential to affect 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 363	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These 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 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain corridor protection with doors	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING **II - MOBRIDGE REGIONAL HOSPITAL** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	**1401 10TH AVE WEST MOBRIDGE, SD 57601**

(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 4 equipped with positive latching hardware at one randomly observed location (construction room). Findings include: 1. Observation on 9/10/24 at 9:45 a.m. revealed the door to the construction room from the corridor close to the kitchen location was not equipped with positive latching hardware. Interview with the environmental services director at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363	A positive self-latch and lock have been installed in the door to the construction room from the corridor close to the kitchen as of 9/27/2024 and will remain locked at all times.	10/18/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431325	A. BUILDING _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL - CAH	1401 10TH AVE WEST MOBRIDGE, SD 57601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted on 9/10/24. Mobridge Regional Hospital was found in compliance.	E 000		

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

John J. Ayoub | CEO | 10/03/2024

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.

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
	48404	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL	1401 10TH AVE W MOBRIDGE, SD 57601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure 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 9/9/24 through 9/12/24. Mobridge Regional Hospital was found not in compliance with the following requirement: S157.	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, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed rooms (environmental services closet and inpatient therapy toilet room). Findings include: 1. Observation on 9/10/24 beginning at 9:10 a.m. revealed the environmental services closet had a janitor's floor sink located in the room. Testing of the exhaust ventilation grille with a paper tissue at the time of the observation revealed there was no working exhaust. 2. Testing on 9/10/24 at 9:20 a.m. of the exhaust ventilation grille for the inpatient therapy toilet room with a paper tissue revealed there was no working exhaust. Interview with the environmental services director at the times of observations confirmed those	S 157	The main drive powering all the exhaust fans in the new medical surgical wing was functional but not set to an effective level and this has been corrected as of 9/27/2024. The exhaust ventilation in the new wing will be checked weekly using the tissue test by the maintenance staff and will be documented on a log. The Maintenance Supervisor added this measure to his QA that will be presented monthly to the QAPI committee until the committee determines otherwise.	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John J. Ayoub — TITLE: CEO — (X6) DATE: 10/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	48404	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOBRIDGE REGIONAL HOSPITAL	1401 10TH AVE W MOBRIDGE, SD 57601

(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 157	Continued From page 1 findings. He revealed the exhaust ventilation for the patient wing building was computer-controlled. He was unaware as to why the exhaust ventilation was not working at those locations.	S 157		