STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	910 EAST 20TH STREET SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 482, Subparts A-D, requirements for hospitals was conducted from 7/15/24 through 7/17/24. Sioux Falls Specialty Hospital LLP was found not in compliance with the following regulations: A505, A749, A940, and A951.	A 000		
A 505	UNUSABLE DRUGS NOT USED CFR(s): 482.25(b)(3) §482.25(b)(3) - Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Expired medications in two of two anesthesia carts were not available for patient use. *Multi-dose vials of medications were dated with a 28-day expiration date from the date of opening. *Single dose vials of medications were not reused or made available for multiple patients. Findings include: 1. Observation on 7/16/24 at 10:00 a.m. of (OR) #14's anesthesia cart revealed: *An opened multi-dose vial dexamethasone (medication for nausea and vomiting) was not labeled with a 28-day expiration date. *An opened multi-dose vial rocuronium (muscle relaxant) 50 mg was not labeled with a 28-day expiration date. *An opened single-dose vial dexamethasone was available for patient use. *An opened single-dose vial phenylephrine (medication for low blood pressure) was available	A 505	The Pharmacist inspected all anesthesia carts immediately post-survey and removed any expired, unlabeled multi-dose vials, multi-dose vials that have exceeded 28 days, and opened single dose vials. Both the Anesthesia and Pharmacy departments will receive education through departmental meetings regarding the correct process of handling expired medications, single and multi-dose vials of medication, and proper labeling of medications with a 28 day expiration date sticker. Education will be documented in meeting minutes. Existing Hospital policies regarding these areas of improvement have been assigned out to all applicable team members. Documentation of policy completion is stored electronically using the hospital's electronic policy manager. Education competencies have been assigned out to all applicable team members using the hospital's electronic education platform. Documentation of completion will be stored electronically and will be monitored by the education coordinator. Education is due by August 16th and annually thereafter. Education completion reports will be sent out weekly to all department directors/ supervisors until 100% completion is achieved. The Anesthesia department has created outdate logs for each anesthesia cart that will be completed monthly. The pharmacist will audit compliance of inspection logs. 5 carts and its corresponding medication inspection log will be audited at random to ensure CRNA compliance of inspecting carts; this will occur monthly for 6 months, until 100% compliance is achieved for 6 consecutive months. Audits will include verification that the CRNA who inspected the cart ensured the following: absence of expired medications in anesthesia carts; multi-dose vials of medications were dated with a 28-day expiration date from the date of opening; Single dose vials of medications were not reused or made available for multiple patients. Audits will be reported to P&T committee and subsequently QAPI. After 100% compliance is achieved for 6 months, committee reporting will cease. The Director of Nurse anesthesia will move to monthly review of each anesthesia cart's medication inspection log and report monthly to the pharmacist in charge of the medication inventory for the anesthesia department. Verification of completion will be signed off by the Pharmacist. Monthly review is an ongoing process and will not cease.	August 26, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	08/19/2024

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.

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A 505	Continued From page 1 for patient use. *A vial of Xylocaine (numbing medication) 50 milliliters (ml) was outdated on 5/2024. *An unlabeled 20 ml syringe filled with a white liquid was in drawer and ready for patient use. -The medication was identified as propofol (sedative). Interview on 7/16/24 at 10:10 a.m. with certified registered nurse anesthetist (CRNA) A revealed: *She had not used any of the opened single dose vials left in the drawer. *Used single-dose vials should have been thrown out prior to the next patient. *Multi-dose vials are good for 28 days from the date it was opened. *Multi-dose vials are dated with the open date and the medication would have expired 28 days from the open date. *Multi-dose vials should be discarded and not used if vials are open with no date. *Propofol should be labeled with the drug, concentration, and expiration date/time. 2. Observation on 7/16/24 at 10:30 a.m. of OR #4's anesthesia cart revealed: *An opened multi-dose vial lidocaine (numbing medication) 500 milligrams (mg) not labeled with a 28-day expiration date. *A multi-dose vial 0.5% lidocaine 250 mg had expired February 2024. *A multi-dose vial of labetalol (lowers blood pressure) 100 mg labeled with an open date of 6/5/2024. *An opened multi-dose vial dexamethasone was not labeled with a 28-day expiration date. Interview on 7/15/24 at 10:35 a.m. with CRNA B revealed:	A 505		

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A 505	Continued From page 2 *Expired medications should not have been used for patients. *Multi-dose vials were good for 28 days from the date it was opened. *Multi-dose vials should be discarded and not used if vials are open with no date. *Labetalol 100 mg multi-dose vial should have been discarded on 7/3/2024. 3. Interview on 7/16/24 at 2:22 p.m. with chief CRNA C revealed: *The anesthesia department was responsible for performing monthly checks for expired medications and supplies. *Anesthesia technicians assisted with these checks. *CRNA's have overall accountability to check for outdated medications. *Multi-dose vials should have been labeled with a 28-day expiration date from the date opened or discarded after use. *An opened multi-dose vial not dated with a 28-day expiration date should be discarded and not used for patients. *Opened single dose vials should have been discarded after drawn up and not placed back into the anesthesia cart. *Single dose vials are used for one-time use. 4. Review of the provider's undated Medication Administration and Disposal policy revealed the provider should have: *Labeled medications transferred from original container to new container, with the medication name, strength/concentration, and amount. *Verified the medication had not expired. *Labeled unopened multi-dose vials with an expiration date that was 28 days from the opening date.	A 505		

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A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure five of five registered nurse (RN) and certified registered nurse (CRNA) staff: *Disinfected the intravenous (IV) port with an alcohol swab for 15 seconds prior to medication administration according to their policy. *Performed hand hygiene after gloves are removed. *Performed hand hygiene when contamination has occurred. *Performed hand hygiene prior to obtaining clean supplies. Findings include: 1. Observation on 7/15/24 at 12:43 p.m. in the Post-Anesthesia Care Unit (PACU) revealed RN D disinfected patient 34's IV port with an alcohol swab for four seconds prior to the administration of normal saline. 2. Observation on 7/15/24 at 1:22 p.m. during patient 34's procedure in operating room (OR) #9 of CRNA E revealed she: *Put on a new a pair of gloves. *Disinfected the IV port with an alcohol swab for five seconds prior to the administration of fentanyl (pain medication). *Opened the anesthesia cart and grabbed a vial of medication out of the drawer with the same	A 749	**Disinfecting IV Port** Hospital policies regarding disinfecting intravenous (IV) ports were assigned out to all applicable team members via the hospital's electronic policy manager. Applicable team members are also required to complete an education module using the hospital electronic education platform. The module provides proper steps to follow when disinfecting IV ports with alcohol prior to access. Records of policy and education completion are stored electronically. Education completion will be monitored by the education coordinator. Education is due by August 16th and annually thereafter. Education completion reports will be sent out, weekly, to all department directors/supervisors until 100% completion is achieved. Department directors/supervisors will monitor 10 IV port disinfections prior to medication administrations per week for 4 weeks. If 100% compliance is achieved, monitoring will move to 10 IV port disinfections prior to medication administrations per month x 5 months, until 6 consecutive months of 100% compliance is achieved. Directors/supervisors will submit data collected from IV disinfection audits to the Infection Prevention Nurse. Audits will be submitted at the end of each week (for 4 weeks), if 100% compliance is achieved, audits will move to monthly and be submitted at the end of each month. The Infection Prevention Nurse will compile all data and report to the QAPI committee quarterly. Identified issues of non-compliance will be addressed through re-education and continued monitoring. If no trends are identified, monitoring will cease. **Hand Hygiene** Hospital policy regarding proper hand hygiene was assigned to all applicable team members via the hospital's electronic policy manager. Applicable team members are also required to complete an education module using the electronic education platform. Records of policy and education completion are stored electronically. Education completion will be monitored by the education coordinator. Education is due by August 16th and annually thereafter. Education completion reports will be sent out, weekly, to all department directors/supervisors until 100% completion is achieved. Team members will demonstrate competency of proper hand hygiene after gloves are removed, when contamination has occurred, and prior to obtaining clean supplies through observation monitoring. Team members that have been assigned the education module will demonstrate competency by passing the test at the end of the education module. To ensure compliance, department directors/supervisors will monitor team members, to ensure proper hand hygiene has occurred. The monitoring log will include the 3 areas of hand hygiene needing improvement. Demonstration of knowledge will also be captured by the directors/supervisors when directly observing hand hygiene through when performing audits. Team member observations will occur 10 times a week for 4 weeks. If 100% compliance is achieved, monitoring will move to 10 times per month x 5 months, until 6 consecutive months of 100% compliance is achieved. Directors/supervisors will submit data collected from hand hygiene observations to the Infection Prevention Nurse. Audits will be submitted at the end of each week (for 4 weeks), if 100% compliance is achieved, audits will move to monthly and be submitted at the end of each month. The Infection Prevention Nurse will compile all data and report to the QAPI committee quarterly. Identified issues of non-compliance will be addressed through re-education and continued monitoring. If no trends are identified, monitoring will continue through existing hand hygiene surveillance.	August 26, 2024

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A 749	Continued From page 4 gloves on her hands. *Removed the gloves, no hand hygiene was performed, and then put on a new pair of gloves. *Removed nursing supplies from anesthesia cart and used on patient. 3. Observation on 7/15/24 at 1:41 p.m. in OR #9 of RN F revealed she: *Put on a new pair of gloves. *Scrubbed patient's 34's right shoulder with chlorhexidine (skin disinfectant). *Reached into a clean drawer with other medical supplies to grab another chlorhexidine prep with the same gloves on her hands. 4. Observation on 7/16/24 at 9:05 a.m. in OR #11 of CRNA H with patient 13 revealed she: *Put on gloves to place oxygen in the patient's nose. *Removed the gloves, opened the anesthesia cart, and removed patient supplies. *Put on a new pair of gloves and grabbed medication from the anesthesia cart. *Removed the gloves, scanned the patient's arm band, and then performed hand hygiene. *Administered an IV medication without disinfecting the IV port with an alcohol swab. *Performed hand hygiene. *Disinfected the IV port with an alcohol swab for two seconds prior to the administration of IV ancef (antibiotic). 5. Observation on 7/16/24 at 9:21 a.m. in OR #16 of CRNA I with patient 12 revealed he: *Disinfected the IV port with an alcohol swab for five seconds prior to the administration of ancef. *Administered 1000 milligrams (mg) of tranexamic acid without disinfecting the IV port with an alcohol swab.	A 749		

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A 749	Continued From page 5 6. Interview on 7/16/24 at 9:54 a.m. with Certified Surgical Technologist (CST) T revealed: *Hand washing education was completed on a yearly basis. *After gloves have been removed the staff should have washed their hands or used hand sanitizer. 7. Interview on 7/15/24 at 2:50 p.m. with OR RN supervisor G revealed she: *Would have expected alcohol-based hand sanitizer or soap and water to have been used before and after glove use. *Would have expected staff to have clean hands prior to obtaining clean supplies from drawers. *Would have expected staff to clean the IV port with an alcohol swab or a chloraprep (skin disinfectant) for 15-30 seconds prior to medication administration. 8. Interview on 7/16/24 at 2:03 p.m. with infection prevention (IP) employee health RN J revealed: *The staff were expected to wash hands after removing gloves and prior to putting on a new pair. *Staff should have clean hands or gloves prior to obtaining clean supplies. *All staff had received yearly education on hand hygiene practices and policies. *Staff had received education on medication administration. *Prior to accessing the IV port, an alcohol swab should have been used for 15 seconds prior to the administration of medications. 9. Interview on 7/16/24 at 2:22 p.m. with chief CRNA C revealed: *Hand hygiene should have been performed after gloves had been removed.	A 749		

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A 749	Continued From page 6 *Hands should have been cleaned prior to getting supplies out of the anesthesia drawers. *Prior to administering IV medications or accessing IV line, the expectation was to use an alcohol swab on the access site for 15 seconds. 10. Interview on 7/17/24 at 3:23 p.m. with chief nursing officer (CNO) K revealed: *"Hand sanitizer machines were placed strategically so patients could see staff use it." *When gloves are removed, staff should have washed their hands before putting on a new pair of gloves. *The expectation would have been to disinfect the IV port with an alcohol swab for 15 seconds prior to medication administration. 11. Review of the provider's undated Handwashing policy revealed: *"All staff and personnel having direct patient care will clean hands at a minimum the following times: -Before and after patient contact, including dry skin contact. -After removing gloves. -Before performing invasive procedures. -After handling equipment, supplies, or linen contaminated with body substances. -Before handing sterile or clean supplies." 12. Review of the provider's undated Standard Precautions policy revealed: *"Gloves are to be changed after contact with each patient and between procedures on the same patient. *Hand hygiene will occur immediately or as soon as feasible after removal of gloves or other personal protective equipment. Alcohol-based hand sanitizers will be used if water is	A 749		

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A 749	Continued From page 7 inaccessible. *Hand hygiene is to be performed before and after each patient contacts, when contamination has occurred and when gloves are removed." 13. Review of the provider's undated Intravenous Therapy-Peripheral-Saline Lock policy revealed: *"Medication infusion and/or flushing: -Swab injection site with an alcohol swab for at least 15 seconds and allow area to dry."	A 749		
A 940	SURGICAL SERVICES CFR(s): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to: *Maintain appropriate temperatures in 15 of 15 operating rooms (OR) within acceptable standards of practice. *Accurately monitor patient's temperatures in the OR to prevent possible hypothermia (low body temperature) and other related complications for 22 of 33 sampled patients (1, 2, 3, 4, 5, 6, 7, 9, 10, 12, 14, 15, 16, 18, 19, 23, 24, 26, 27, 28, 31, and 32). *Ensure 4 of 33 sampled patients (9, 14, 15, and 31) maintained a skin temperature greater than 90 degrees F during their surgical procedure. *Ensure OR temperatures were within acceptable standards of practice during 31 of 33 sampled	A 940	**OR Temp** The Operating Room and Anesthesia departments have been educated on acceptable standards of practice regarding OR temperatures. The Hospital policy has been updated and assigned out to all applicable team members via the Hospital's electronic policy manager and will be assigned out annually thereafter. Team member policy completion is documented and stored electronically. All operating room and anesthesia team members are required to complete an education module using the hospital's electronic education platform. Education completion will be monitored by the education coordinator. Education is due by August 15th and annually thereafter. Records for completion of education will be stored electronically. Education completion reports will be sent out, weekly, to all department directors/supervisors until 100% completion is achieved. The Operating Room temperatures have been adjusted to maintain temperatures within acceptable standards of practice. The Director of Plant Operations and maintenance has locked the thermostat to maintain temperature. Temperature will continue to be monitored and documented on a daily basis and any temperatures outside of the acceptable parameters will require a work order for Hospital maintenance to address and correct promptly. All work orders and any necessary measures taken place will be documented. To monitor for sustained compliance, the OR temperature logs will be audited monthly for 12 months by the Accreditation Specialist and Risk Manager. Audit will include completeness of temperature log, verify temperatures are within acceptable standards of practice, and if not, was maintenance notified. All data will be compiled and reported by the Accreditation Specialist or Risk Manager, quarterly to the Safety Committee and subsequently at the QAPI committee. Identified issues of non-compliance will be addressed through re-education and continued monitoring until 100% compliance is achieved for 12 consecutive months. Routine daily temperature logs will be maintained. Hospital policy is assigned out annually. **Patient Temperature** The Operating Room and Anesthesia departments will be educated at departmental meetings on the importance of accurately monitoring patient temperature to prevent hypothermia and other related complications. Education given will be documented in meeting minutes. All operating room and anesthesia team members will be assigned out the revised hospital policy that includes information on monitoring patient temperature and warming measures. All operating room and anesthesia team members are required to complete an education module using the hospital electronic education platform. This module contains information on maintaining patient normothermia and the rationale.	August 26, 2024

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A 940	Continued From page 8 patient's procedures (2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, and 33). Findings include: 1. Observation on 7/15/24 at 2:09 p.m. in OR #11 revealed the room's digital thermometer temperature reading was 64.4 degrees Fahrenheit (F). Review of the provider's temperature and humidity log from, 3/1/24 through 7/15/24 of all 15 OR's revealed the temperatures were documented to be less than 68 degrees F. Observation on 7/16/24 at 9:05 a.m. in OR #11 for patient 13's procedure revealed, the recorded temperature was 64.2 degrees F. Observation on 7/16/24 at 9:21 a.m. in OR #16 for patient 12's procedures revealed, the recorded temperature was 65 degrees F. Review of the 33 sampled patients' charts related to OR temperatures during their procedures revealed: *Thirty-one patients' procedures were performed outside the acceptable standards of practice for OR temperatures of 68-73 degrees F. -Those temperature ranges had been 62 degrees F to 67 degrees F. *Twenty-two patients had a documented skin temperature during their surgical procedure had fallen below 95.9 degrees F. *Four patients had a documented skin temperature in the 80's during their surgical procedure. The OR temperatures were: -64 degrees F for patient 9. -65 degrees F for patient 14.	A 940	**Continued from Page 8** Education completion will be monitored by the education coordinator. Education is due by August 16th and annually thereafter. Records for completion of education will be stored electronically. Education completion reports will be sent out, weekly, to all department directors/supervisors until 100% completion is achieved. The Director of Anesthesia is trialing and implementing different modalities for monitoring patient temperature. To audit effectiveness of temperature probes and verify the patient is normothermic, the Accreditation Specialist and Risk Manager will audit 10 anesthesia records per week times 4 weeks. If 100% compliance is achieved, audits will move to 10 anesthesia record audits monthly x 5 months until 6 consecutive months of 100% compliance is achieved. Standards of temperature monitoring will be established based on efficacy and appropriateness. Policy and education updates will occur accordingly. All data compiled will be reported by the Accreditation Specialist or Risk Manager, quarterly, to the QAPI committee. Identified patient temperatures outside of normothermia will be addressed through re-education and continued monitoring. If no trends are identified, routine documentation will continue; anesthesia record audits and committee reporting will cease.	

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A 940	Continued From page 9 -66 degrees F for patient 15. -65 degrees F for patient 31. Interview on 7/17/24 at 1:10 p.m. with chief nursing officer (CNO) K revealed: *She worked with the Accreditation Commission for Health Care (ACHC) on temperatures in the OR. *The ACHC recommended performing a risk assessment. *The provider changed their OR parameters for temperatures based on evidence. *She worked with the previous director of plant operations but he is no longer with them. -She was unable to determine the reference or resource used to score the risk assessment. *The provider had based their decision on low surgical site infection rates for them. *The provider had chosen the temperature ranges based on the temperatures the OR rooms were running. *She stated,"Surgeons drive the practice and temperatures are set based on their preference." *They had not seen any patient complications, but there was the potential. Interview on 7/17/2024 at 1:25 p.m. with medical director U revealed: *Patient's temperatures of 95.9 degrees F to 98.6 degrees F would have been generally within the accepted range. *If patient's temperatures were outside the accepted range, they would have provided an intervention. *Patient's temperatures outside the accepted range can lead to an increase in complications such as: -Infection. -Coagulation (blood clotting) issues.	A 940		

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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) COMPLETION DATE
A 940	Continued From page 10 -Blood sugar control. -Longer hospital stays. *Skin temperatures were taken with a probe in the armpit or any area on the skin that would have given an accurate reading. *Skin temperatures provides a trend to determine treatment. *A negative trend would have been a patient's temperatures changing more rapidly. *They would have been more concerned more with a downward trend than an upward trend. *If temperatures are trending down, they would have wanted to get a more accurate measurement of their temperature by obtaining a core temperature or using a different type of thermometer. Interview on 7/17/24 at 1:44 p.m. with chief certified registered nurse anesthetist (CRNA) C revealed: *Ideal core (temperature of the body's internal organs) temperatures range had been 96.8 degrees F to 100.4 degrees F. *Skin temperatures ran lower than a core temperature. *The provider performed both core and skin temperatures. *Temperatures could have varied depending on where you had measured on the body. *When a patient's temperature had been trending down, other interventions should have been carried out. Such as: -Forced air warming. -Heated intravenous fluids. *The standard of practice was to warm the patient in the pre-operative area first. *If interventions had been unsuccessful, the anesthesiologist would have been notified. *The patient temperatures that had been	A 940		

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	430090	A. BUILDING _____ B. WING _____	07/17/2024

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A 940	Continued From page 11 documented in the 80's was not normal. *There would have been a need for accurate documentation of how temperatures were obtained. *"The OR temperatures were too cold and have always been a topic of discussion." Review of the provider's undated Temperature and Humidity in the OR policy revealed: *Purpose of the policy is to maintain OR temperatures in accordance with recommended standards, the interest of the patient, and environmental safety. *Resources for the policy are: -Association of PeriOperative Registered Nurses (AORN) Guidelines for PeriOperative Practice, 2019 edition. -American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) Standard 170-2008. -Association for the Professional in Infection Control and Epidemiology (APIC) text, 4th Edition. *"Temperature ranges are established by performing an annual life safety risk assessment." *The temperature range for the OR is 60 degrees F-72 degrees F. *Patient temperatures will be monitored in the OR to maintain normothermia and ensure patient safety. Review of the provider's undated risk assessment for OR temperature parameters revealed: *Temperature range assessed was for 60 degrees F to 67 degrees F in the OR. *Risk to patient is low. *Risk to team member is none. *Risk to facility is none.	A 940		

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A 940	Continued From page 12 *Risk to surgeon is none. *Financial risk is none. *Overall risk level is low. *Risk assessment had no documented date of approval. *No documentation or evidence was listed to support the provider's findings or conclusions. Review of AORN 2020 edition, pg. 329 revealed hypothermia happens when body temperature is less than 96.8 degrees F. Review of ASHRAE Standard 170-2008 for operating room temperature range is 68-75 degrees F. Review of APIC text, 4th edition design standards for operating rooms recommended a temperature of 68 degrees F to 75 degrees F. Review of the Administrative Rules of South Dakota 44:75:13:23 ventilating systems revealed: *"A facility shall ensure its ventilating systems maintain temperatures, minimum air changes of outdoor air per hour, minimum total air changes, and relative humidities as follows: -For operating rooms, sixty-eight to seventy-three degrees Fahrenheit or twenty to 22.8 degrees centigrade, three outdoor, twenty total, and twenty to sixty percent humidity."	A 940		
A 951	OPERATING ROOM POLICIES CFR(s): 482.51(b) Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.	A 951	All contaminated instruments will be transported in a leak proof and puncture resistant container that is labeled biohazard. Operating Room management will provide education to operating room team members on process improvement of transporting contaminated instruments at departmental meeting. Education given will be included in meeting minutes. All OR team members will complete an education module and be assigned hospital policy on proper transportation of contaminated instruments using the hospital's electronic education and policy platforms. Record of education and policy completion is stored electronically.	August 26, 2024

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A 951	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure four of four carts holding contaminated instruments containing blood and bodily fluids had been transported in a sealed container and were labeled as biohazardous. Findings include: 1. Observation on 7/15/24 at 2:09 p.m. in operating room (OR) #11 revealed: *Surgical instruments used during the operation had been separated and placed into different containers with no lids on them. *The containers had been placed on a table with wheels for transportation to central processing (department where re-usable instruments are cleaned and repackaged). *The needles and sharp objects had been separated and discarded separately. *All the used instruments were sprayed with a pre-klenz (pre-treatment gel) prior to transporting to central processing. *A large drape had been placed over the instruments in the containers. *The table and instruments were moved out of the OR and rolled to central processing for decontamination and reprocessing. *The drape covering the instruments was not labeled as biohazardous and puncture-resistant. Observation on 7/16/24 at 9:38 a.m. in OR #15 revealed: *Five containers of contaminated instruments consisting of scissors, drills, tweezers, and screwdrivers were on a long table with wheels. *The instruments had been separated and treated with pre-klenz and were not placed in	A 951	Continued from Page 13 Education completion will be monitored by the education coordinator. Education is due by August 16th and annually thereafter. Education completion reports will be sent out, weekly, to all department directors/ supervisors until 100% completion is achieved. The CSR Supervisor will monitor compliance of proper transportation. To measure compliance, observations will occur 10 times a week for 4 weeks. If 100% compliance is achieved, monitoring will move to 10 times per month x 5 months, until 6 consecutive months of 100% compliance is achieved. The CSR Supervisor will submit data collected from observations to the Infection Prevention Nurse. Audits will be submitted at the end of each week (for 4 weeks), if 100% compliance is achieved, audits will move to monthly and be submitted at the end of each month. The Infection Prevention Nurse will compile all data and report to the QAPI committee, quarterly. Identified issues of non-compliance will be addressed through re-education and continued monitoring. If no trends are identified, documented observations will cease, however, routine monitoring is ongoing.	

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A 951	Continued From page 14 sealed containers. *A large drape was placed over the table and covered the contaminated instruments. *The drape was not labeled as biohazardous. *The table was pushed into the OR corridor and rolled to central processing. Interview on 7/16/24 at 9:45 a.m. with central sterilization room technician S revealed: *Instruments were precleaned in the OR prior to transportation to central processing. *Instruments were separated into containers with needles and other sharps discarded. *She confirmed: -The containers for transporting the used instruments did not have lids. -A biohazardous label was not on the drape. -This had been their process used to transport contaminated instruments. Observation on 7/16/24 at 10:20 a.m. in the OR corridor revealed: *Contaminated instruments had been placed in non-sealed containers on a large table with wheels. *Instruments had been pretreated with pre-klenz. *Instruments had been covered with a large drape. *There was not a biohazardous label on the drape. Interview on 7/16/24 at 10:30 a.m. with OR supervisor registered nurse (RN) G revealed: *"This is our policy on transportation of contaminated items. *Contaminated instruments are sprayed in the OR, separated, placed into containers, and a large drape is placed over the instruments. *We have done it this way for years."	A 951		

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A 951	Continued From page 15 Interview on 7/16/24 at 2:03 p.m. with infection prevention (IP) employee health RN J revealed: *The provider used Association of perioperative Registered Nurses (AORN), Association for Professional in Infection Control and Epidemiology (APIC), and Association for the Advancement of Medical Instrumentation (AAMI) national guidelines to guide their practice and write policies. *Contaminated instruments should have been in a sealed, puncture resistant container, and labeled as biohazard. *"We were told this at one time because this is how we transport our dirty scopes." Review of the provider's undated Handling, Care, and Transportation of Contaminated Items policy revealed: *Purpose -"To provide guidelines for OR scrub team members for the careful and safe return of instruments to decontamination area for cleaning and decontamination prior to resterilization." *Reference AAMI 6.4: -"Prior to leaving the OR, the scrub team members will remove all sharps from instruments and power equipment to be reprocessed and placed in appropriate sharps container. -Disassemble all instruments that have come in direct patient contact by using a separate basin or towel taking care to keep instrument trays together by inventory. -Cover table or place contaminated instruments in a sealed container to transport to decontamination room to prevent spread of pathogens." Review of AAMI national guidelines ST 79:2017	A 951		

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A 951	Continued From page 16 pg. 36 revealed: *"To help prevent damage to reusable items and avoid contamination of the environment, transport carts or other system should: -Be designed to prevent items from falling over or off during transport. -Be covered or closed. *Prior to transportation, items contaminated with blood and other potentially infectious materials should be placed in a container that is puncture-resistant, leak-proof on the bottom and sides, labeled as biohazardous, and sealed. *Rationale: Materials contaminated with blood or other bodily fluids can serve as a sources of infection to personnel unless the materials are completed contained. Containment minimizes the possibility of airborne or contact spread of microorganisms."	A 951		

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	430090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2024**

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SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the 2012 Life Safety Code (LSC) (existing health care occupancy) was conducted from 7/15/24 to 7/16/24. Sioux Falls Specialty Hospital LLP building 1 was found not in compliance with 42 CFR Part 482.41(b)(1), requirements for hospitals. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K211 and K321 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 maintain a protected path of egress at two randomly observed locations (second floor stairwell one and northwest exit). Findings include: 1. Observation on 7/15/24 at 1:50 p.m. revealed the second floor corridor in front of stairwell one had a Hoyer lift and a portable x-ray machine kept in the corridor at the stairwell door location. The access to the egress door could be reduced	K 211	Means of egress at the hospital will be maintained free of obstruction. Items found in 2nd floor corridor stairwell and northwest lower level exit egress hallways have been moved into unused areas; Hospital wide education will be sent to discuss importance of keeping means of egress maintained free of all obstructions and directed to report areas or move item to appropriate location. Sustained compliance will be maintained by daily monitoring of egress hallways by all department managers/supervisors; if equipment is found in any area it will be reported to the department manager/ supervisor in the area of concern and immediate action will be taken to remove the obstructing items; daily rounds will never cease. In addition, the Quality Specialist performs environmental rounds monthly and any areas of obstruction are reported to applicable department manager/supervisor using electronic platform. Both locations have been added into rounding software. Also, signage has been hung in areas cited during survey indicating areas that must remain clear of obstruction. Results of environmental rounds will be reported to the QAPI committee quarterly.	August 26, 2024

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

CEO | 08/09/2024

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
	430090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2024**

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SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

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K 211	Continued From page 1 by the equipment kept in that location. 2. Observation on 7/15/24 at 3:45 p.m. revealed the egress corridor at the northwest exit one had seven plastic totes measuring 24 inches by 30 inches by 18 inches tall in the path of egress from the ground floor and in the elevator ground floor discharge location. Further observation revealed a sign was posted indicating how to handle items delivered to the building at that location. 3. Interview with the environmental services manager at the time of the observation confirmed that condition. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 211		
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 Area Automatic Sprinkler	K 321	**Soiled Utility Room Corridor Door and Generator Room Door**--The soiled utility room corridor door on 3rd floor and generator room door hinges have been adjusted and now close and latch properly. These 4 doors have been added to the existing "Security Sensitive Door Log". Rounds occur monthly by facility engineer to ensure proper closure and latch and are documented. The addition of these doors to monthly rounds will be discussed at the next Safety Committee meeting. The Director of Plant operations and Maintenance educated facility engineers and any team member that utilizes that space on the reasoning and importance that these door close and latch correctly and to place a work order if they don't. The corrections made to these doors and the change made to rounding log will be reported to Safety Committee and monthly rounding will continue indefinitely. **Lower Level Storage (4 Rooms)**--During survey lower level storage rooms 1-4 were not equipped with spring hinges, therefore they did not close and latch on their own. The corrective action is that spring hinges have been added to all 4 lower level storage room doors to make them self-closing and latching. These 4 doors have been added to the existing "Security Sensitive Door Log". Rounds occur monthly by facility engineer	August 26, 2024

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K 321	Continued From page 2 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: Based on observation, testing, and interview, the provider failed to maintain six separate hazardous areas (storage rooms) as required. Findings include: 1. Observation and testing on 7/15/24 at 2:20 p.m. revealed room 309, the soiled utility room corridor door, would not close and latch with the operation of the closer. 2. Observation and testing on 7/15/24 at 3:00 p.m. revealed the 1-1/2 hour fire-rated door to the generator room in the lower level would not close and latch with the operation of the closer. 3. Observation and testing on 7/15/24 at 3:15 p.m. revealed the lower level material storage room (storage room 2) was over 100 square feet in area with a quantity of combustible items. The corridor door was equipped with spring hinges, but the door would not close and latch upon the action of the spring hinges. 4. Observation and testing on 7/15/24 at 3:20 p.m. revealed the lower level hospitality room (storage room 1) was over 100 square feet in area with a quantity of combustible items. The	K 321	Continued from Page 2 to ensure proper closure and latch and are documented. Signage is placed on each door stating, "Notice - Keep Door Closed". The Director of Plant operations and Maintenance educated facility engineers and any team member that utilizes that space that doors must remain closed and latched. The changes made to the 4 lower level storage rooms and the change made to rounding log will be reported to the Safety Committee and monthly rounding will continue indefinitely.	

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	430090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2024**

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K 321	Continued From page 3 corridor door was equipped with spring hinges, but the door would not close and latch upon the action of the spring hinges. 5. Observation and testing on 7/15/24 at 3:25 p.m. revealed the lower level storage room 3 was over 100 square feet in area with a quantity of combustible items. The corridor door was equipped with spring hinges, but the door would not close and latch upon the action of the spring hinges. 6. Observation and testing on 7/15/24 at 3:30 p.m. revealed the lower level storage room 4 was over 100 square feet in area with a quantity of combustible items. The corridor door was equipped with spring hinges, but the door would not close and latch upon the action of the spring hinges. 7. Interview with the director of plant operations at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

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	430090	A. BUILDING **02 - BUILDING 2** B. WING _____	**07/16/2024**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the 2012 Life Safety Code (LSC) (existing health care occupancy) was conducted from 7/15/24 to 7/16/24. Sioux Falls Specialty Hospital LLP building 2 was found not in compliance with 42 CFR Part 482.41(b)(1), requirements for hospitals. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	The housekeeping room (2 doors) spring hinges both have been adjusted and now close and latch properly. The storage room corridor door closer has been adjusted and the door now closes and latches properly. These 3 doors have been added to the existing "Security Sensitive Door Log". Rounds occur monthly by facility engineer to ensure proper closure and latch and are documented. The addition of these doors to monthly rounds will be discussed at the next Safety Committee meeting. The Director of Plant operations and Maintenance educated facility engineers and any team member that utilizes that space on the reasoning and importance that these door close and latch correctly and to place a work order if they don't. The corrections made to these doors and the change made to rounding log will be reported to Safety Committee and monthly rounding will continue indefinitely.	August 26, 2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING **02 - BUILDING 2** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

(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 321	Continued From page 1 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: Based on observation, testing, and interview, the provider failed to maintain two separate hazardous areas (storage rooms) as required. Findings include: 1. Observation and testing on 7/15/24 at 4:15 p.m. revealed the housekeeping room was over 100 square feet in area with quantities of combustibles in storage. The room had two corridor doors equipped with spring hinges. The corridor doors would not close and latch with the operation of the spring hinges. 2. Observation and testing on 7/15/24 at 4:15 p.m. revealed the storage room was over 100 square feet in area with quantities of combustibles. The room had a corridor door equipped with a closer. The corridor door would not close and latch with the operation of the closer. 3. Interview with the director of plant operations at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING **02 - BUILDING 2** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

(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

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
	430090	A. BUILDING _____ B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	910 EAST 20TH STREET SIOUX FALLS, SD 57105

(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 482, Subpart B, Subsection 482.15, Emergency Preparedness, requirements for Hospitals and Specialized Hospitals, was conducted from 7/15/24 through 7/16/24. Sioux Falls Specialty Hospital LLP was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 08/09/2024

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
	10583	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL, LLP	910 E 20TH ST SIOUX FALLS, SD 57105

(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 health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, Critical Access Hospital, and Rural Emergency Hospital Facilities, was conducted from 7/15/24 through 7/17/24. Sioux Falls Specialty Hospital, LLP was found not in compliance with the following requirement: S226.	S 000		
S 226	44:75:04:09(1) Tuberculin Screening and Testing Requirements Tuberculin screening requirements for healthcare personnel are as follows: (1) Each new healthcare personnel shall receive an initial individual Tb risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of employment or direct patient care is considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation, from the transferring healthcare facility or personnel, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any healthcare personnel who has a newly recognized positive reaction to the skin test or TB	S 226	The Director of Operations for IHA, who is responsible for provider credentialing, has updated the provider credentialing checklist that is sent to providers at the time they are applying for privileges. This checklist now includes the request for providers to include verification that the provider has had a TB assessment within the last 12 months. An internal report was generated to identify previously credentialed providers who did not have a TB assessment on file. From this report, a spreadsheet was developed as a tracking tool to record when the Director of Operations for IHA receives documentation that a TB assessment has been completed and added to the provider's credentialing file. By utilizing the internal tracking spreadsheet that the Director of Operations for IHA will be recording the receipt of outstanding TB assessments on, the Infection Prevention / Employee Health Nurse will select at random, 5 providers on the list to audit that the TB assessment has been provided and is filed in the provider's credentialing file. Auditing by the Infection Prevention / Employee Health Nurse will be performed weekly, until all credentialed providers have proof of a TB assessment. One time discussion regarding updates made to the provider credentialing checklist and process change will be reported to the Credential's Committee at the next scheduled meeting. Audit results will be reported monthly at subsequent Credential's Committee Meetings until compliance is reached. The Credential's Committee Meeting Minutes are discussed at Medical Executive Meetings and ultimately Management Committee. Compliance of 100% of receipt of TB assessments is expected on all existing and new credentialed providers to support a permanent process change. Internal education of the process change, updates to the credentialing checklist, and the tracking spreadsheet was provided to current IHA team members by the Director of Operations for IHA and documented in the departmental meeting minutes. The hospital's revised credentialing policy was assigned out to team members through the hospital's electronic policy manager as an educational competency for the credentialing team to read and be educated on. Education about all required elements of the credentialing checklist, TB assessment, and the corresponding hospital policy will be provided during IHA new hire orientation and reflected on the new hire orientation checklist maintained in the team member's HR file.	August 26, 2024

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

TITLE: CEO

(X6) DATE: 08/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10583	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL, LLP	910 E 20TH ST SIOUX FALLS, SD 57105

(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 226	Continued From page 1 blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on credentialing file review, policy review, and interview, the provider failed to ensure a documented tuberculosis (TB) assessment had been performed on eight of eight sampled credentialed providers (C, L, M, N, O, P, Q, and R). Findings include: 1. Review of the credentialing files for the above listed providers revealed there were no documented TB test results on file. Review of the provider's undated Employee Health TB Assessment Program revealed: *All Sioux Falls Specialty Hospital team members and anesthesia associate team members will meet the tuberculin screening requirements as follows: -Each new healthcare worker will receive the two-step method of TB skin test to establish a baseline. -If a test from another provider has been completed within the previous year, the second TB skin test will be performed. Interview on 7/17/24 at 3:41 p.m. with chief nursing officer K revealed: *They would not have received the provider's TB information as part of the credentialing process. *Physicians that are not employees of the facility are not part of the TB surveillance program. *She agreed the physicians probably should have been a part of that TB screening process.	S 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING _____ B. WING _____	R 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	910 EAST 20TH STREET SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS An onsite revisit survey was conducted on 8/29/24 for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals for all previous deficiencies cited on 7/17/24. All deficiencies have been corrected and no new non-compliance was found. Sioux Falls Specialty Hospital LLP was found in compliance with all regulations surveyed.	{A 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

(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 revisit survey was conducted on 8/29/24 for compliance with 42CFR 482.41(b)(1) requirements for hospitals for all previous deficiencies cited on 7/16/24. All deficiencies have been corrected and no new non-compliance was found. Sioux Falls Specialty Hospital Llp building 1 was found in compliance with all regulations surveyed.	{K 000}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430090	A. BUILDING **02 - BUILDING 2** B. WING _____	R **08/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL LLP	**910 EAST 20TH STREET** **SIOUX FALLS, SD 57105**

(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 revisit survey was conducted on 8/29/24 for compliance with 42CFR 482.41(b)(1) requirements for hospitals for all previous deficiencies cited on 7/16/24. All deficiencies have been corrected and no new non-compliance was found. Sioux Falls Specialty Hospital Llp building 2 was found in compliance with all regulations surveyed.	{K 000}		

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

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

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
	10583	A. BUILDING: _____ B. WING _____	R 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX FALLS SPECIALTY HOSPITAL, LLP	910 E 20TH ST SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Compliance/Noncompliance Statement An onsite revisit licensure health survey was conducted on 8/29/24 for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, for all previous deficiencies cited on 7/17/24. All deficiencies have been corrected and no new noncompliance was found. Sioux Falls Specialty Hospital LLP was found in compliance with all regulations surveyed.	{S 000}		

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