STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431334	A. BUILDING _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER - CAH	745 EAST 8TH STREET WINNER, SD 57580

(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 485.601-485.649, requirements for Critical Access Hospitals, was conducted from 3/3/26 to 3/5/26. Winner Regional Healthcare Center-CAH was found not in compliance with the following requirements: C914 and C924.	C 000		
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, policy review, and manufacturer's instructions for use (IFU) review, the provider failed to ensure that three of three Lifepak 20e's (a defibrillator) 20 were checked daily per the manufacturer's IFU. Findings include: 1. Observation and interview on 3/3/26 at 3:36 p.m. with registered nurse (RN) A on the medical surgical unit and emergency department (ED) revealed: *A crash cart with a Lifepak 20e defibrillator. *The charge nurses were responsible for checking the defibrillators daily in the medical-surgical unit and the ED. *A daily crash cart checklist was completed, verifying: -The staff checked the defibrillator according to the model instructions.	C 914	**1. Corrective Action for** Affected **Equipment** All Lifepak 20e defibrillators (medical-surgical unit, emergency department, and cardiac rehab) were immediately reviewed. • A complete operator checklist per manufacturer IFU was performed on all defibrillators on 03/10/2026. • Defibrillators were verified to be in safe working condition, including testing both plugged and unplugged from AC power. • Missing elements of the daily operator checklist were completed and documented.	

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

CEO | 19.MAR.26

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

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C 914	Continued From page 1 -A defibrillator test was completed while the machine was plugged in and unplugged from a power source. -The joules (amount of electric energy delivered). -The user test. -The test strip was printed. *She stated each defibrillator would complete an auto self-test daily at 3:00 a.m. and print a test strip indicating either a pass or fail result. -That printed test strip would then be attached to the logbook located at the nursing station verifying it was completed. *She confirmed the defibrillators on the medical-surgical unit and the ED were not tested when they were unplugged, and was unsure why the staff were documenting 360 joules on the checklist, because the defibrillator had completed a self-test. *She was unaware of the manufacturer's IFU recommendations to complete the operator's checklist daily. 2. Observation and interview on 3/4/26 at 11:35 a.m. with RN B in the cardiac rehab department revealed: *A crash cart with a Lifepak 20e defibrillator. *She verified that the defibrillator completed a self-test daily at 3:00 a.m., and a test strip would have been printed and then placed in the logbook located in the cardiac rehab nurse's desk. *The daily crash cart checklist was completed as performed in the medical-surgical unit and ED. *She was unaware of the manufacturer's IFU recommendations to complete the operator's checklist daily. 3. Review of the provider's August 2025 Crash Carts policy revealed: *"Medical and ER [emergency room] Crash Carts	C 914	**2. Systemic Corrective Action** To prevent recurrence: • The **Crash Cart Policy** was revised to include full manufacturer IFU requirements for daily defibrillator checks, including: o Physical inspection o Power source verification o Battery function (including unplugged testing) o Cable/electrode inspection o Printer functionality o Completion of operator checklist steps • A **standardized defibrillator** checklist aligned with the Lifepak 20e IFU has been implemented across all departments. • Daily checks now require **validation beyond auto self-test,** including manual verification steps. **3. Staff Education** • All nursing staff (RN/LPN), including charge nurses and cardiac rehab staff, were educated on: o Manufacturer IFU requirements o Revised policy expectations o Proper completion of daily defibrillator checks •	

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C 914	Continued From page 2 must be checked daily by the charge nurse or his/her designee. *If equipment is not working, notify maintenance immediately. *Cardiac Rehab cart will be checked by cardiac rehab nurse." *The policy did not specify the required daily checks for the defibrillator. 4. Review of the manufacturer's 2008 IFU for the Lifepak 20 Defibrillator/Monitor Operator's Checklist revealed: *"1. Check [the] auto test printed report for: -Self test failed. -Self test did not complete-Connect to [the] test plug. *2. Inspect physical condition for: -Foreign substances. -Damages or cracks. *3. Inspect [the] power source for: -AC power connector plugged into [the] unit and [the] AC power source; -AC Mains LED is lit. *4. Check therapy and ECG [electrocardiogram] electrodes for: -Use by date. -Spare electrodes [are] available. *5. Examine accessory cables for: -Cracking, damage, broken or bent parts or pins, and paddle surfaces for pitting. *6. Disconnect the defibrillator from [the] AC power, wait 2 seconds, press ON and check for: -Momentary SELF-TEST messages, and momentary illumination of LEDs. -Services LED is lit. -LOW BATTERY/CONNECT TO AC POWER message. *7. Check ECG printer for: -Adequate paper supply.	C 914	• Education completed by **03-15-2026** • New staff will receive this education during orientation • Staff will be required to complete yearly competencies on Lifepak testing. **4. Monitoring and Quality Assurance** • Nurse managers or designees will perform: o **Weekly audits x 4 weeks,** then o **Monthly audits x 3 months** of crash cart and defibrillator documentation. • Audits will verify: o Completion of full checklist o Accuracy of documentation • Results will be reported to the **Quality Assurance/Performance Improvement (QAPI) Committee.** **5. Responsible Party** Chief Nursing Officer and Nurse Managers **6. Completion Date**	March 15 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 914	Continued From page 3 -Ability to print. *8. Confirm [the] therapy cable [is] connected to [the] defibrillator to perform [the] cable check: -If QUIK-COMBO therapy cable is connected: --Confirm [the] test plug [is] connected to [the] therapy cable. --Press ANALYZE button. --After ANALYZING NOW message, look for REMOVE TEST PLUG message. *9. Reconnect the defibrillator to AC power and then power off [the] device."	C 914		
C 924	PREMISES ARE CLEAN AND ORDERLY CFR(s): 485.623(b)(4) (4) The premises are clean and orderly; and This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the premises were clean regarding: *Three of three handwashing sinks that had visible calcium/mineral buildup on the basin and fixture surfaces. *Two of two cabinets composed of damaged wood surfaces that were not cleanable and maintained in a sanitary condition. *Three of three cabinets beneath the sinks (storage areas) that had accumulated dirt, rust, and calcium/mineral buildup. *One of three base cabinets without intact caulking where the countertop met the wall to prevent water entry behind the wall. Findings include: 1. Observation on 3/3/26 at 2:38 p.m. in the nourishment room revealed: *A countertop with exposed, damaged wood. *The countertop contained a handwashing sink	C 924	**1. Corrective Action for Affected Areas** The following areas were addressed: • All identified sinks (nourishment room, medication room, soiled utility room) were: o Deep cleaned to remove calcium/mineral buildup using appropriate descaling agents. • Cabinets beneath sinks were: o Emptied, cleaned, and disinfected. • Damaged wood cabinets: o Assessed by maintenance. o Interim measure: sealed and covered to create a cleanable surface. o Replacement plan initiated. New cabinets and sinks ordered **3/17/2026** • Nourishment room cabinet: o Caulking repaired on **03/12/2026** to prevent water intrusion.	

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C 924	Continued From page 4 that contained visible calcium/mineral buildup. *Under the sink, the storage area contained accumulated dirt and rust. *The area where the countertop met the wall lacked intact caulking, allowing water to drip behind the wall and creating the potential for mold growth. 2. Observation on 3/3/26 at 2:50 p.m. in the medication room on the medical-surgical unit revealed: *A base cabinet that contained a handwashing sink with a large amount of visible calcium/mineral buildup. *The storage area under the sink contained accumulated dust, rust, dirt, and calcium/mineral buildup on plumbing fixtures. 3. Observation on 3/3/26 at 3:45 p.m. in the soiled utility room on the medical-surgical unit revealed: *A wood base cabinet containing a handwashing sink with a large amount of visible calcium/mineral buildup. *The storage under the sink contained accumulated dust, rust, dirt, and calcium/mineral buildup on the plumbing fixtures. -This storage beneath the sink was constructed of wood, making the surfaces difficult to clean and disinfect. 4. Interview on 3/3/26 at 3:55 p.m. with chief nursing officer H regarding the above findings revealed she: *Was aware of the calcium/mineral buildup on handwashing sinks. *Stated, "We have hard water here." *Was aware the cabinets were made of wood and were difficult to clean.	C 924	**2. Systemic Corrective Action** • A new **Environmental Cleaning** Policy was developed addressing: o Cleaning expectations for **non-patient care areas.** o Routine cleaning of sinks, fixtures, and under-sink storage o Required cleaning frequencies (daily, weekly, monthly) • A **preventive maintenance schedule** was implemented for: o Inspection of cabinetry, caulking, and surfaces • Materials that are not cleanable (e.g., damaged wood) will be: o Replaced with **non-porous, cleanable surfaces**	

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C 924	Continued From page 5 *Was not aware that the cabinet in the nutrition room lacked intact caulking between the cabinet and the wall, and agreed that it needed to be addressed. 5. Interview on 3/3/26 at 4:00 p.m. with housekeeping aide G regarding the above findings revealed: *The sinks were cleaned when the calcium/mineral buildup became noticeably visible. *She stated, "It depends on whether we are not short-staffed, but we try to clean them at least weekly." *She confirmed the storage underneath the sinks were not cleaned. 6. Interview on 3/4/26 at 2:00 p.m. with infection control/employee health I regarding the above findings revealed: *She was aware that the handwashing sinks contained significant calcium/lime buildup, and these issues were forwarded to leadership. *She had notified maintenance about the lack of caulking on the countertop in the nourishment room the previous year, but the issue was not addressed. *Housekeeping were responsible for cleaning the sinks and areas beneath the cabinets. *She agreed that wood surfaces cannot be adequately cleaned or disinfected. *She agreed these conditions had the potential to harbor microorganisms and increase the risk for contamination and infection transmission. 7. Interview on 3/4/26 at 3:00 p.m. with supervisor-housekeeping F revealed: *When sinks contained significant calcium buildup, the staff were instructed to use	C 924	**3. Staff Education** • Housekeeping and nursing staff were educated on: o Revised cleaning policy o Proper descaling techniques for hard water buildup o Responsibility for shared areas (e.g., medication rooms) • Education completed by **03/15/2026.** **4. Monitoring and Quality Assurance** • Environmental rounds will be conducted: o **Weekly x 4 weeks** then o **Monthly x 3** months • Rounds will include: o Inspection of sinks, cabinets, and under-sink areas o Verification of cleaning logs • Findings will be reported to **Infection Control and QAPI Committee.**	

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C 924	Continued From page 6 Lime-A-Way (a cleaning product used to dissolve and remove tough mineral deposits caused by hard water) at least weekly. *The cabinets under the sinks were not cleaned. She stated, "We do not do any cleaning of the cabinets under the sink." *The sink in the medication room was only cleaned when the nursing staff were present. *She confirmed there were no provider policies indicating a cleaning process for rooms other than patient rooms. 8. Observation and interview on 3/5/26 at 8:25 a.m. with maintenance assistant D and chief executive officer E in the nourishment room, medication room, and soiled utility room located on the medical-surgical nursing unit revealed: *They agreed the three sinks contained visible calcium/mineral buildup. *They agreed the two cabinets had damaged wood and were not cleanable or maintained in good condition. *They agreed the three cabinets beneath the sinks contained accumulated dirt, rust, and calcium/mineral buildup. *They agreed the cabinet located in the nourishment room lacked intact caulking where the countertop met the wall, allowing water to enter behind the wall, creating the potential for mold growth. The provider did not have any policies or procedures for cleaning areas other than patient rooms.	C 924	**5. Responsible Party** • Environmental Services Supervisor • Infection Interventionist, and • Maintenance Director **6. Completion Date**	March 20 2026

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
	431334	A. BUILDING _____ B. WING _____	03/04/2026

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E 000	Initial Comments A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospital, was conducted on 3/4/2026. Winner Regional Healthcare Center - CAH was found in compliance.	E 000		

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

CEO 19.MAR.26

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	431334	A. BUILDING **01 - PATIENT BUILDING** B. WING _____	**03/04/2026**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 3/4/2026 for compliance with 42CFR 485.623(d)(1), requirements for critical access hospitals (and swing bed). Winner Regional Healthcare Center - CAH was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	19-MAR-26

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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
	51775S	A. BUILDING: _____ B. WING _____	03/05/2026

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S 000	Compliance/Noncompliance Statement A licensure health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospitals, Specialized Hospital, and Critical Access Hospital facilities, was conducted from 3/3/26 through 3/5/26. Winner Regional Healthcare Center was found not in compliance with the following requirement: S416.	S 000		
S 416	44:75:14:17-18 Ventilation All air supply and air exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at the discharge end of the system. All air supplied to an operating room, delivery room, nursery or any other sensitive area shall be delivered at or near the ceiling of the area served. All air exhausted from the area shall be removed near floor level. At least two exhaust outlets shall be used in each operating and delivery room. Exhaust wall outlets shall be located not less than three inches (0.076 meters) above the floor. A ventilation system in operating, delivery, emergency, isolation, central sterilization, or nursery room shall be a ducted system. A ventilation system using the building concealed space (return air plenum) from a clean room is not acceptable. The facility shall ensure that each ventilation system serving an operating room, delivery room, nursery, isolation room, and laboratory sterile room is equipped with a minimum of two filter beds. Filter bed number one must be located upstream of the conditioning equipment and must have a minimum efficiency of thirty percent. Filter bed number two must be located downstream of the conditioning equipment and must have a	S 416	**1. Corrective Action for Affected Areas** • Operating Room (OR) temperature set points were immediately adjusted on **March 3, 2026**, to maintain compliance within the required range of 68–73°F. • Maintenance staff verified calibration and functionality of HVAC controls and monitoring systems to ensure accurate readings. • A full assessment of the HVAC system serving the OR and sterile storage areas was initiated	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 19 MAR 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 416	Continued From page 1 minimum efficiency of ninety percent. Central systems using one hundred percent outdoor air and serving other than sensitive areas must be provided with filters rated at eighty percent efficiency. These filter efficiencies must be warranted by the manufacturer and shall be based on the 2017 edition of the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) Standard 52.2 dust spot test method with atmospheric dust. The exhausts from all laboratory hoods in which infectious or radioactive materials are processed must be equipped with filters with a ninety-nine percent efficiency. Filter frames must be durable and must provide an airtight fit with the enclosing ductwork. All joints between filter segments and the enclosing ductwork must have a positive seal against air leakage. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, interview, policy review, and the Administrative Rules of South Dakota review, the provider failed to: *Maintain appropriate temperatures within acceptable standards of practice of 68 to 73 degrees Fahrenheit (F) in two of two operating rooms (OR) from October 2025 through March 2026. *Maintain appropriate humidity levels within acceptable standards of practice of 20 to 60 percent in one of one sterile storage room from November 2025 through February 2026. Findings include: 1. Observation on 3/4/26 at 9:30 a.m. in OR rooms 1 and 2 revealed a temperature of 64 degrees F.	S 416	**2. Systemic Changes to Prevent Recurrence** • A **comprehensive policy titled "Temperature and Humidity Monitoring in Surgical and Sterile Areas"** was developed and implemented by **March 15, 2026,** which includes: o Required temperature and humidity ranges per regulatory standards o Defined responsibilities for monitoring (Surgery and Maintenance Departments) o Required documentation of readings and corrective actions o Escalation protocol for out-of-range findings • Established **standard operating procedures** requiring: o Immediate notification to Maintenance when readings fall outside acceptable ranges o Real-time documentation of all corrective actions taken	

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WINNER REGIONAL HEALTHCARE CENTER	745 E 8TH ST WINNER, SD 57580

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S 416	Continued From page 2 2. Review of the OR's October 2025 through March 2026 temperature logs revealed: *The temperature ranged between 64 to 65 degrees F every day of the week during these months. *There were no documented corrective actions taken when the temperatures were out of range. 3. Review of the sterile storage room's November 2025 through February 2026 humidity logs revealed that: *November 2025 humidity levels were out of range for 2 of 30 days with no documented corrective actions. *December 2025 humidity levels were out of range for 12 of 31 with no documented corrective actions. *January 2026 humidity levels were out of range for 8 of 31 days with no documented corrective actions. *February 2026 humidity levels were out of range for 5 of 28 days with no documented corrective actions. 4. Interview on 3/5/26 at 12:15 p.m. with OR supervisor C revealed: *She stated, "The temperatures in the OR have consistently been lower than the recommended temperature of 68 degrees F. I was told this could not be fixed." *She stated that an alarm indicating the temperatures and humidity levels were out of range would only only alert on her computer if she logged on. *If she had gotten an alarm on her computer, she would have notified maintenance, but any corrected actions were not documented. *She agreed that the temperatures in the OR and the relative humidity levels in the sterile storage	S 416	**3. Staff Education** • All Surgery Department staff and Maintenance personnel received education by **March 15, 2026,** on: o Regulatory requirements for temperature and humidity o New policy and documentation expectations o Use of the monitoring and alert system • Education documentation is maintained by the facility. **4. Monitoring and Quality Assurance** • Daily temperature and humidity logs will be: o Completed and reviewed each day by Surgery staff o Reviewed weekly by the Maintenance Director • The **Surgery Department** will: o Conduct weekly audits for 30 days, then monthly audits for 3 months to ensure compliance o Verify that out-of-range readings have documented corrective actions • Results will be reported through the **Quality Assurance and Performance Improvement (QAPI) program** and trended for sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51775S	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 416	Continued From page 3 room were out of range for the months above. 5. Interview on 3/5/26 at 12:25 p.m. with maintenance assistant D revealed: *The temperatures in the OR were set between 64 and 65 degrees F. *He stated, "We have done this to help with the humidity." *He was aware that the temperatures were set lower than the recommended temperature of 68 degrees F. *He confirmed the set point in the sterile storage room was set at 29.4 percent humidity. *The alarms for the temperatures and humidity levels generate a notification through the computer system, which would then be addressed by either maintenance or surgery staff. *He confirmed that any corrective actions were not documented. *He stated he could not find any policy that discussed temperature and humidity levels in the OR or the sterile storage room, but surgery may have a policy. 6. Review of the provider's October 2020 Designated Shelf Life policy revealed: *"Humidity should be between 20%-60%. *Temperature should remain between 68 [degrees]-73 [degrees] F." 7. 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."	S 416	**5. Responsibility** • **Maintenance Director:** Oversight of HVAC system performance and corrective actions • **Surgery Supervisor:** Daily monitoring compliance and documentation • **Chief Nursing Officer (CNO):** Oversight of policy implementation and compliance • **Quality Director:** Audit and reporting through QAPI **6. Completion Date** • Full compliance achieved	April 15 2026

South Dakota Department of Health

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