STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431314	A. BUILDING _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME - CAH	102 MAJOR ALLEN POST OFFICE BOX 70D MARTIN, SD 57551

(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 485.608 - 485.645 requirements for Critical Access Hospitals (CAH) and Long-Term Care Services ("swing beds"), was conducted from 4/23/24 through 4/25/24. Bennett County Hospital was found not in compliance with the following requirements: C812, C914, C962, C1046, C1102, and C1208.	C 000		
C 812	COMPLIANCE FED, ST, AND LOCAL LAWS AND REGS CFR(s): 485.608(a) The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients. This STANDARD is not met as evidenced by: Based on record review and interview the provider failed to ensure thirty of thirty sampled patients (1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29 and 30) had received notification of physician availability. Findings include: 1. Review of patients 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29 and 30's electronic medical record (EMR) revealed all patients had not received written notification of a physician not being available in the hospital 24 hours a day. Interview on 4/25/24 at 11:00 a.m. with chief nursing officer B regarding patients receiving physician availability revealed she had not been aware that patients needed to have notification for that.	C 812	1. Chief Nursing Officer (CNO) or designee will review and update admission paperwork that will include written notification of a physician not being available in the hospital 24 hours a day for all patients to review and sign. All patients sited in deficiency have been discharged so cannot not be corrected. Education will be provided to all staff involved in admission process by CNO or designee on 5/22/2024. CNO or designee will perform audit to verify all inpatients have the signed written notification of a physician not being available in the hospital 24 hours a day completed in their chart. Audit will be done on 100% of inpatients for six months and results will be taken to Quality Assurance Performance Improvement (QAPI) committee which consists of all department managers, CEO, medical director, and minutes reviewed monthly by Governing Board. Audit will be brought to QAPI every monthly for analysis of data and instruction on how to proceed.	06/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shandel Anson	Chief Executive Officer (CEO)	5/13/2024

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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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 and interview, the provider failed to implement an effective preventative maintenance plan as evidenced by: *One of one hand sink in isolation room 112 did not have a water supply. *One of one hand sink in room 106 leaked water from the drain line onto the floor. *No exhaust ventilation for bathrooms in patient rooms 102, 103/104 (with a shared bathroom), 106, 107, and 114. *Window air conditioners had a black substance covering the adjustable louvers in patient rooms 105, 106, 112, 114, the trauma room, and the emergency room. *Thirteen of 40 hand sanitizers located in the hallways outside of patient rooms for staff to sanitize their hands with were expired. Findings include: 1. Observation on 4/23/24 from 9:00 a.m. to 10:00 a.m. revealed: *The hand sink in isolation room 112 did not have a water supply. *The hand sink in room 106 leaked water from the drain line onto the floor. *There was no exhaust ventilation for bathrooms in patient rooms 102, 103/104 (with a shared bathroom), 106, 107, and 114. *Window air conditioners had a black substance	C 914	1.Isolation room as been moved from room 112 to room 115 with two functional sinks. Maintenance manager completed this transition on 5/7/2024. Sink in room 112 was fixed on 4/26/24 by maintenance manager, room 106 sink was fixed on 04/24/2024 to working order with no leaks in the drain line by maintenance manager. Sink checks will be added to the weekly maintenance walkthrough checklist. The weekly maintenance walkthrough checklist will be reported to QAPI committee monthly by Maintenance manager. The QAPI committee will do analysis of data and instruction on how to proceed. Rooms 102, 103/104, 106, 112, 114 will be fixed to have ventilation in bathrooms by maintenance manager. Fans have been ordered and will be place in the bathrooms of 102, 103/104, 106, 112, 114 which will ensure working ventilation in these bathrooms. Ventilation checks in all patient bathrooms will be added to the weekly maintenance walkthrough checklist which is completed by maintenance manager and CNO. The weekly maintenance walkthrough checklist will be reported to QAPI committee monthly by Maintenance manager. The QAPI committee will do analysis of data and instruction on how to proceed. Addendum 5/20/24- Room 107 ventilation fan in bathroom will be fixed and checks of bathroom ventilation fans in all patient rooms will be added to the weekly maintenance walk through.	06/09/2024

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C 914	Continued From page 2 covering the adjustable louvers in patient rooms 105, 106, 112, 114, the trauma room, and the emergency room. Interview on 4/25/24 at 10:20 a.m. with director of maintenance C revealed: *He had been the director of maintenance for about three months. He had been hired as a maintenance person about one year ago. *He was not aware the sink in room 112 did not have running water. *He was not aware the drain line to the sink in room 106 leaked water. *He was not aware the mechanical exhaust ventilation for the bathrooms was not working. *They cleaned the filters in the air conditioners periodically, but it was not scheduled or documented when that occurred. *They did not clean the adjustable louvers or the inside of the air conditioners. *They did not monitor the air conditioners for cleanliness. *They checked patient rooms for cleanliness of floors and walls but did not check the sinks to verify they were functional. *He had not received much training from the previous director or maintenance. *He agreed they did not have an effective preventative maintenance plan. 2. Random observations on 4/23/24 from 1:45 p.m. to 2:15 p.m. in the hallways of the hospital revealed: *There were 40 Purell hand-sanitizing dispensers in the hallways of the hospital. *Each dispenser had a bottle of hand sanitizer attached to it with an expiration date printed on the front. *Thirteen of the 40 bottles of hand sanitizer	C 914	Continued from page 2: Window air conditioners in rooms 105, 106, 112, 114, trauma room were all cleaned to be free of black substance covering the adjustable louvers on 5/7/2024. Housekeeping staff and all staff will be educated on cleaning of air conditioners by CNO or designee on 5/22/2024. Checking of air conditioner cleanliness in all patient rooms and emergency department will be added to the weekly maintenance walkthrough checklist which is completed by maintenance manager and CNO. The weekly maintenance walkthrough checklist will be reported to QAPI committee monthly by Maintenance manager. The QAPI committee will do analysis of data and instruction on how to proceed. 2. All expired hand-sanitizers were removed by maintenance on 5/8/2024 from use and discarded. Checking all wall and free-standing hand-sanitizers expiration dates will be added to the weekly maintenance walkthrough checklist. Education will be provided to all maintenance staff on 5/22/2024 by CNO or designee. The weekly maintenance walkthrough checklist will be reported to QAPI committee monthly by Maintenance manager. The QAPI committee will do analysis of data and instruction on how to proceed.	06/09/2024

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C 914	Continued From page 3 observed were past their expiration date. Interview on 4/24/24 at 9:45 a.m. with housekeepers I and J regarding the expired hand sanitizer bottles in the hallways revealed: *It was their responsibility to replace the hand sanitizer bottles when they were empty. *They would have checked the level of hand sanitizer in the bottles as they cleaned throughout the day. *They were not aware there was an expiration date on the bottles. Interview on 4/24/24 at 3:00 p.m. with maintenance/environmental services/emergency preparedness director C regarding the expired hand sanitizer bottles in the hallways revealed: *The housekeeping staff were educated at general orientation to check for expired products. *He expected the hand sanitizers to have been upon expiration. *He agreed the hand sanitizer bottles were not being monitored for expiration dates. Interview on 4/25/24 at 1:40 p.m. with administrator A regarding the expired hand sanitizer bottles in the hallways revealed: *They had an over-supply of hand sanitizer left from the Covid-19 supplies they had received. *She thought it was the housekeepers' job to monitor for expiration dates on the hand sanitizer bottles. *Sometimes other staff would have replaced the bottles when they were empty. *It was her expectation staff would discard expired products when found. *She stated they did not have a specific policy for monitoring and discarding expired hand sanitizer	C 914		

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C 962	Continued From page 4	C 962		
C 962	GOVERNING BODY OR RESPONSIBLE INDIVIDUAL CFR(s): 485.627(a) The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on interview and review of the governing body By-Laws, the provider failed to ensure the original dated and signed By-Laws were available for review. Findings include: 1. Review of a copy of the governing body By-Laws provided by administrator A revealed no: *Date or signatures of the past or present governing body. *Addendums to the By-Laws. *List of the governing body members. Interview on 4/24/25 at 2:00 p.m. with administrator A revealed she was not aware she had only provided a copy of the governing body By-Laws. She stated she would bring the dated and signed By-Laws for review. Interview on 4/24/25 at 4:30 p.m. with administrator A revealed she had: *Been unable to locate the dated and signed By-Laws. *Contacted the governing body president, the administrator consultant, and the previous administrator. She stated those individuals were not aware the original signed copy was not available.	C 962	1. Bennett County Hospital remains unable to locate the original copy of the By-Laws with signatures and addendums. Copy of By-laws that was provided during survey, will be updated to include names, positions, signatures, and dates of all current board members. Any addendums will be added to this document as they occur. Hard copy of this document will be kept in the CEO office, and electronic copy kept. Location will be checked by CEO monthly and will be reported to QAPI committee monthly by CEO. The QAPI committee will do analysis of data and instruction on how to proceed.	06/09/2024

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C 962	Continued From page 5 *She agreed it was important to have the original dated and signed governing body By-Laws, any addendums that had been added, and changes in the governing body members available.	C 962		
C1046	NURSING SERVICES CFR(s): 485.635(d)(1) Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Outdated supplies were not available for patient use in the emergency department, room 102, and in two of three ambulances. *Outdated medications were not available for patient use in the ambulance service medication cupboard. Findings include: 1. Observation on 4/23/24 at 9:30 a.m. of supplies in room 102 revealed: *The room was set-up as a labor and delivery room. *Outdated supplies included: -Thirteen single-use packages of lubricating jelly all with the expiration date of 11/2/22. -One umbilical cord clamp expired 9/30/23. -Three of eight speculums expired 12/27/23.	C1046	1. CNO or designee will immediately remove and discard all expired supplies from room 102 including: thirteen single-use packages of lubricating jelly all with the expiration date of 11/2/22, one umbilical cord clamp expired 9/30/23, and three of eight speculums expired 12/27/23. Policy/procedure for check and removing expired supplies will be reviewed/revised by CNO or designee. Checklist for assigned staff checking supplies will be reviewed/revised by CNO or designee. All nursing staff will be educated on policy/procedure and checklist on 5/22/2024. Checklist will be audited by CNO or designee for six months and brought to QAPI committee. The QAPI committee will do analysis of data and instruction on how to proceed. 2. CNO or designee will immediately remove and discard all expired supplies from non-trauma room in the emergency department including: one of two DeLee suction catheters expired in June 2020, on suction tubing expired 9/1/22, one of four Salem Sump Duel Lumen stomach tube expired 8/31/22, and one 20 milliliter syringe expired on 2/1/22. Policy/procedure for check and removing expired supplies will be reviewed/revised by CNO or designee. Checklist for assigned staff checking supplies will be reviewed/revised by CNO or designee. Education will be given to all staff by CNO or designee on 5/22/2024. Checklist will be audited by CNO or designee for six months and brought to QAPI committee. The QAPI committee will do analysis of data and instruction on how to proceed.	06/09/2024 06/09/2024

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C1046	Continued From page 6 Interview on 4/24/24 at 9:35 a.m. with registered nurse (RN) G revealed there was no process to regularly check for outdated supplies in the labor/delivery room. 2. Observation on 4/23/24 at 10:05 a.m. in the emergency department non-trauma room revealed outdated. Those supplies included: *One of two DeLee suction catheters expired in June 2020. *One suction tubing expired on 9/1/22. *One of four Salem Sump Duel Lumen stomach tube expired on 8/31/22. *One 20 milliliter syringe expired on 2/1/22. 3. Observation on 4/24/24 at 2:05 p.m. of three of three facility owned ambulances. There were outdated supplies in two of three ambulances including: *Ambulance 1191: -One suction tubing expired on 4/12/24. -Two intravenous (IV) start kits expired in March 2024. -One I-gel airway size 2.5 expired on 3/16/24. *Ambulance 1193: -Three of three King LTS-D airways sizes 2.5 expired on 8/1/21, 5.0 expired on 1/11/21, and 3.0 expired on 2/1/23. -Two I-gel airways size 2 expired in January 2023 and size 4 expired in October 2023. -Suction tubing expired on 9/1/22. -Nasopharyngeal airway sizes 14 french and 24 french expired on 3/28/24. -Two IV start kits expired on 2/28/23. 4. Observation on 4/24/24 at 3:00 p.m. of the locked ambulance cupboard revealed three of three epinephrine injection single-dose auto injectors 0.15 milligram expired in March 2024,	C1046	Continued from page 6: 3. Ambulance director or designee will immediately remove and discard all expired supplies from three of three ambulances including: one suction tubing expired 4/12/2024, two intravenous (IV) start kits expired March 2024, one I-gel airway size 2.5 expired 8/1/2021, three of three King LTS-D airways sizes 2.5 expired on 8/1/21, 5.0 expired on 1/11/21, and 3.0 expired on 2/1/23, two I-gel airways size 2 expired in January 2023 and size 4 expired in October 2023, suction tubing expired on 9/1/22, Nasopharyngeal airway sizes 14 french and 24 french expired on 3/28/24, and two IV start kits expired on 2/28/23 Ambulance staff assigned to checking for expired supplies weekly was educated on 4/25/2024 by ambulance director that when expired medication is found, it should be removed immediately from ambulance. Policy/procedure and checklist will be reviewed/revised by ambulance director. Check list will be submitted to QAPI committee monthly with goal of 100% compliance. The QAPI committee will do analysis of data and instruction on how to proceed. 4. Ambulance department director or designee will immediately remove all expired medications from three of three ambulances including: 3 epinephrine injection single-dose auto injectors 0.15 milligrams expired March 2024. Ambulance staff assigned to checking for expired medications weekly was educated on 4/25/2024 by ambulance director that when expired medications is found, it should be removed immediately and destroyed by emergency room Registered Nurse or Pharmacist. Policy/procedure and checklist will be reviewed/revised by Ambulance director or designee. Check list will be submitted to QAPI committee monthly with goal of 100% compliance. The QAPI committee will do analysis of data and instruction on how to proceed.	06/09/2024 06/09/2024

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C1046	Continued From page 7 Interview on 4/24/24 at 3:10 p.m. with ambulance director E revealed: *Staff were assigned to different areas to check for outdated supplies and medications. *She had not realized the checks for outdated supplies was not completed. *The staff person in charge of checking for outdated medications had noted it on her checklist, but had not informed ambulance director E. 5. Observation on 4/23/24 at 10:15 a.m. of supplies in the trauma room revealed: *I-gel oral airway compartment contained the following: -Size for a 25-35 kilogram (kg) patient expired on 11/2022. -Size for a 10-25 kg patient expired on 1/2023. -Size for a 5-12 kg patient expired on 3/2024. -Size for a 2-5 kg patient expired on 11/2023. *Chest tube kit contained the following: -One dry seal chest drain expired on 11/7/22. -Three 0 Perma-hand silk suture expired on 2/29/24. -Two polyline minor procedure drapes expired on 8/30/22. -Two sets of suction tubing expired on 9/1/22. -Two #15 scalpels expired on 11/31/23. -One # 15 scalpel expired on 12/31/22. -Four 20 french trocar catheters expired on 7/1/22. -One 32 french trocar catcher expired on 5/1/22. *Vital signs monitor machine contained the following: -Four packages of pediatric huggable electrodes (used to monitor the patient's heart rate and	C1046	Continued from page 7: 5. CNO or designee will immediately remove and discard all expired supplies from trauma room in the emergency department including: size for a 25-35 kilogram (kg) patient expired on 11/2022, size for a 10-25 kg patient expired on 1/2023, size for a 5-12 kg patient expired on 3/2024, size for a 2-5 kg patient expired on 11/2023, one dry seal chest drain expired on 11/7/2022, three 0 Perma-hand silk suture expired on 7/1/2022, two polyline minor procedure drapes expired 8/30/2022, two sets of suction tubing expired on 9/1/22, two #15 scalpels expired on 11/31/23, one # 15 scalpel expired on 12/31/22, four 20 french trocar catheters expired on 7/1/22, one 32 french trocar catcher expired on 5/1/22, vital signs monitor machine contained the following: four packages of pediatric huggable electrodes (used to monitor the patient's heart rate and rhythm) expired on 8/19/23, one package of pediatric huggable electrodes expired on 10/28/23, airway supplies compartment contained the following: an Ambu laryngeal mask size 5 expired on 2/5/22, an Ambu laryngeal mask size 3 expired on 3/17/22, one King LTS-D # 2 (laryngeal airway) expired on 11/1/22, one Centurion alligator forcep expired on 3/31/22, suction machine supplies contained one Salem suction kangaroo port expired on 5/31/23, Glide Scope (a scope used to help with endotracheal intubation) equipment contained the following: one LoPro size 2 spectrum expired on 11/27/23, one Mac size 4 expired on 8/27/21, one Mac size 4 expired on 7/7/23, crash cart equipment contained the following: one pediatric carbon dioxide detector expired on 3/27/24 one Ambu carbon dioxide detector for adults expired on 3/24/24.	06/09/2024

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C1046	Continued From page 8 rhythm) expired on 8/19/23. -One package of pediatric huggable electrodes expired on 10/28/23. *Airway supplies compartment contained the following: -An Ambu laryngeal mask size 5 expired on 2/5/22. -An Ambu laryngeal mask size 3 expired on 3/17/22. -One King LTS-D # 2 (laryngeal airway) expired on 11/1/22. -One Centurion alligator forcep expired on 3/31/22. *Suction machine supplies contained one Salem suction kangaroo port expired on 5/31/23. *Glide Scope (a scope used to help with endotracheal intubation) equipment contained the following: -One LoPro size 2 spectrum expired on 11/27/23. -One Mac size 4 expired on 8/27/21. -One Mac size 4 expired on 7/7/23. *Crash cart equipment contained the following: -One pediatric carbon dioxide detector expired on 3/27/24. -One Ambu carbon dioxide detector for adults expired on 3/24/24. Interview on 4/23/24 at 2:20 p.m. with chief nursing officer B regarding the removal of expired supplies revealed: *The night shift would have checked for outdated supplies on a monthly basis. *They did not have a checklist to sign off on once the task had been completed. *She had been aware that there were some outdated supplies. Review of the provider's January 2007 Expiration Dates policy revealed:	C1046	Continued from page 8: Policy/procedure for check and removing expired supplies will be reviewed/revised by CNO or designee. Checklist for assigned staff checking supplies will be reviewed/revised by CNO or designee. All nursing staff will be educated on policy/procedure and checklist on 5/22/2024 by CNO or designee. Checklist will be audited by CNO or designee for six months and brought to QAPI committee with goal of 100% compliance. The QAPI committee will do analysis of data and instruction on how to proceed.	

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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
C1046	Continued From page 9 *"Two days before the end of every month the nursing staff will remove any items that will be outdated. You should pull and item that has an expiration date for the upcoming month.(example: If it is December 30, you must pull items off for January also)" *"This includes both emergency rooms, OB room, all patient rooms, nursing station, crash carts, med room, etc. The pharmacist will be in charge of all meds. Central supply will be in charge of the central supply room and IV room. We will use an expiration supply list as a reference to any items that has expiration dates, Duties are assigned as follows:" -"Day shift nursing aid will be in charge of the large ER [emergency room], nursing station and patient rooms." -"Night shift nursing aid will be in charge of the small ER and [obstetrics] OB room." -"Night shift Nurse will be in charge of the crash carts and med room."	C1046		
C1102	RECORDS SYSTEM CFR(s): 485.638(a)(1) (1) The CAH maintains a clinical records system in accordance with written policies and procedures. This STANDARD is not met as evidenced by: Based on record review, interview, patient checklist review, and policy review, the provider failed to ensure 7 of 30 sampled patients (9, 14, 15, 17, 19, 21, and 22) electronic medical records (EMR) had complete information to include: discharge summaries, separate records for swing bed, and complete nursing documentation. Findings include: 1. Review of patient 15's 4/6/24 inpatient record	C1102	Admission paperwork and checklist will be review/revised by CNO or designee. Discharge paperwork and checklist will be reviewed/revised by CNO or designee. Weekly audits will be completed by CNO or designee on one hundred percent of inpatients and swing beds. Audit will include: completion of discharge summaries signed by provider, separate record for swing bed, complete/accurate wound assessments,	06/09/2024

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	431314	A. BUILDING _____ B. WING _____	04/25/2024

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C1102	Continued From page 10 revealed she had been discharged to swing bed on 4/8/24. There was no physician summary for her inpatient stay. 2. Review of patient 17's 12/3/23 inpatient record revealed he had been discharged to home on 12/4/24. There were discharge instructions given by the nurse. There was no physician discharge summary. 3. Review of patient 19's 1/18/24 through 1/19/24 inpatient record revealed she had only one over midnight inpatient stay. She was admitted to swing bed on 1/19/24. There was no separate record started for her swing bed stay. 4. Review of patient 21's 4/15/24 swing bed admission record revealed: *She had diagnoses that included cellulitis and a sacral ulcer. *Her admission nursing assessment indicated: *She had end stage dementia. *She had a wound on her coccyx. There were no measurements or description of this wound. *Her Braden Assessment Flowsheet indicated she had a risk factor of "Loss of appetite." -"Patients with 1 or more Risk Factors are referred to Provider & Registered Dietitian (RD) for possible Nutrition Consult." A yes answer was chosen. -No RD assessment was located. The nursing narrative included "1850 [6:50 p.m.] Wound assessed on EZ graph with noc [nights] shift RN [registered nurse]. See paper chart. Aquaphor applied to buttock." 5. Review of patient 22's 4/17/24 swing bed admission revealed: *Her initial nursing assessment indicated:	C1102	Continued from page 10: Registered Dietitian assessment on patients who are referred for nutrition consult, braden assessment flowsheet on all admissions, admission dietary assessments, and only patient or Power of Attorney signing admission paperwork, do not resuscitate (DNR)/do not intubate (DNI) paperwork, or any other hospital forms. All staff involved in getting hospital forms signed will be educated on policy/procedure and checklist on 5/22/2024 by CNO or designee. Checklist will be audited by CNO or designee weekly for three months and brought to QAPI committee with goal of 100% compliance. The QAPI committee will do analysis of data and instruction on how to proceed.	

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C1102	Continued From page 11 -She fractures of her right patella and left upper humerous. -The Braden Assessment Flowsheet had not been completed -The dietary assessment had not been completed. -The initial wound status assessment indicated she had a blister to the lower part of her left shin. -The measurements were length 2 cm (centimeter) and width 1 cm. It was dry with no odor. -Factors that would affect wound healing was diabetes. -Her risk factor for the provider and RD to be notified for a possible consult included multiple fractures. *A 12 hour nursing assessment completed on 4/24/24 at 6:30 a.m. revealed no documentation regarding her left shin blister. *A 12 hour nursing assessment completed on 4/24/24 at 6:30 p.m. revealed 3 areas marked on an outline of a body. Those areas were: -"A" her left upper arm, "B" her right knee, and "C" her left lower calf. It indicated the wounds were from trauma, they were dry, and there was no odor. Interview on 4/25/24 at 10:10 a.m. with chief nursing officer B revealed: *They had done record reviews on the documentation of activities of daily living and baths. *No record reviews had been completed on nursing documentation. *She agreed there was missing documentation in patient's records.	C1102		

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C1102	Continued From page 12 6. Review of patient 9's electronic medical record (EMR) revealed: *He: -Had been admitted on 11/7/23 with a diagnoses of agitation/delirium. -Had his brother sign his admission papers. *There was document in patiet 9's EMR indicating who his power of attorney for healthcare was. 7. Review of patient 14's EMR revealed: *She: -Had been admitted on 2/2/19 with diagnosis of a gastrointestinal bleed and was placed on end of life care. -Had her boyfriend sign her do not resuscitate (DNR)/do not intubate (DNI) form. *There was document in patient 14's EMR indicating who her power of attorney for healthcare was. Interview on 4/25/23 at 11:00 a.m. regarding the location of the power of attorney for healthcare documents for patient 9 and patient 14 revealed: *She had tried to locate the documents, but was unable to locate them for patient 9 and patient 14. *She agreed that people should not sign hospital forms for patients unless they are the power of attorney for healthcare and the provider should have had copy to support their wishes.	C1102		
C1208	INFECTION PREVENT SURVEIL & CONTROL OF HAIs CFR(s): 485.640(a)(3) The infection prevention and control includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and that the program also addresses	C1208	1. Infection control policy/procedures will be reviewed/revised by CNO or designee. Education on correct hand hygiene practices will done to all staff by CNO or designee. Education will include that hand hygiene (hand washing or use of antiseptic gel or foam) should have be performed: after handling all bodily secretions, and after removal of gloves.	06/09/2024

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C1208	Continued From page 13 any infection control issues identified by public health authorities; and This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection control practices were maintained for: *Hand hygiene and glove use by one of one registered nurse (RN) H and one of one physician assistant-certified (PA-C) F during care provided for patient 24. *Terminal cleaning of the floors in patient rooms with an approved disinfectant. Findings include: 1. Observation on 4/23/24 from 9:50 a.m. through 10:15 a.m. of RN H while she completed and electro-cardiogram (EKG) and placed intravenous (IV) access to patient 24 in the emergency department (ED). Those observations included: *Patient 24 was lying on an ED bed. *RN H had gloves on and completed an EKG. *She removed the EKG machine leads from patient 24 and pushed the EKG machine to the other side of the ED room. *Without changing gloves she: -Removed an uncleanable blood pressure cuff from patient 24's right arm and placed it back in the vital sign machine basket. -Gathered supplies from the supply cabinet to obtain IV access and take blood samples. -Placed those supplies on an overbed table without placing a barrier first. -Opened the packages that contained the IV abbocath, chlorohexadine prep swab, IV site dressing, tape, and sterile gauze 4 by 4's. -Used the chlorohexadine prep swab to disinfect the skin of patient 24's right antecubital space. She did not swab in a back-and-forth motion for 60 seconds. She did not allow the chlorohexadine	C1208	Continued from page 13: Thirty hand hygiene observations/audits will be performed monthly by CNO or designee (no end date, this audit will be on going). These audits will be brought to QAPI committee. The QAPI committee will do analysis of data and instruction on how to proceed. Education on any patient care equipment should be sanitized between uses with PDI Sani-Cloth wipes and allowed to air dry. Education will be done to all staff by CNO or designee. Ten disinfection of reusable equipment observations/audits will be performed monthly by CNO or designee for three months. These audits will be brought to QAPI committee. The QAPI committee will do analysis of data and instruction on how to proceed. Education on placing barrier down to place clean supplies on for intravenous (IV) start procedure will be provided to all medical staff by CNO or designee. Ten observations/audits will be performed monthly by CNO or designee for three months. These audits will be brought to QAPI committee. The QAPI committee will do analysis of data and instruction on how to proceed. 2. Terminal Cleaning policy/procedures will be reviewed/revised by housekeeping manager or designee. Disinfectant used one patient rooms will be changed to include Environmental Protection Agency registration number that will kill germs and disinfect. All housekeeping staff will be educated on the use of new disinfectant on floors for terminal cleanings.	06/09/2024

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C1208	Continued From page 14 to dry prior to inserting the IV needle. -After she had obtained IV access there was blood from around the IV site. She used an alcohol wipe to wipe the blood and placed it on the overbed table. She had blood smear on her right hand thumb and first finger of her gloves. She wiped it off with the same alcohol wipe she had used to wipe the blood away from the patient's IV access site. -She continued to fill three tubes of blood for laboratory testing. -Placed a dressing over the IV access site and taped the tubing to patient 24's arm. -Gathered the used supplies and disposed of them. -Did not sanitize the overbed table. -Placed the blood pressure cuff on patient 24's left arm. -Removed her gloves and without performing hand hygiene she took a pen out of her uniform pocket and placed identification stickers with the patients name on the blood tubes. Observation on 4/23/24 at 10:00 a.m. of PA-C revealed he had gloves on, used his stethoscope to listen to patient 24's heart and lung sounds. After his physical examination, he left the room and removed his gloves, did not perform any hand hygiene, or disinfect the bell of his stethoscope, then started to document in the computer. Interview on 4/23/24 at 4:00 p.m. with RN H confirmed the above findings. She stated she gets busy and forgets to remove her gloves and perform hand hygiene between tasks. She was not sure who sanitized the EKG machine after use. She had not realized she should have placed a barrier down or sanitized the overbed table prior	C1208	Continued from page 14: Housekeeping manager will audit ten terminal cleanings for three months that new disinfectant is being used on all terminal cleans in patient room. These audits will be brought to QAPI monthly by the housekeeping manager. The QAPI committee will do analysis of data and instruction on how to proceed.	

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C1208	Continued From page 15 to placing supplies on it. Review of the provider's last revised 6/16/22 Infection Control policy revealed: *Hand hygiene (hand washing or use of antiseptic gel or foam) should have been performed: *After handling all bodily secretions. *After removal of gloves. *Any patient care equipment should have been sanitized between uses with PDI Sani-Cloth wipes and allowed to air dry. 2. Interview on 4/23/24 at 2:45 p.m. with housekeepers I and J regarding the cleaning of a room after discharge revealed they used 3M 24H 3-in1 Floor Cleaner to mop the floors of rooms after discharge. Review of the 3M 24H 3-in1 Floor Cleaner manufacturer's instructions for use revealed the product did not have an Environmental Protection Agency registration number and made no claim to kill germs or disinfect. Interview on 4/23/24 at 3:00 p.m. with the maintenance/environmental services/emergency preparedness director C revealed housekeeping staff were to use 3M 25L HB Quat Disinfectant on the floors of rooms for terminal cleaning after a patient is discharged. Interview on 4/23/24 at 3:30 p.m. with administrator A who was also the infection preventionist for the provider revealed she agreed that floors, should have been disinfected when terminal cleaning had been completed after a patient was discharged. Review of the providers "Patient Room Terminal	C1208		

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C1208	Continued From page 16 (Discharge/Transfer) Cleaning and Disinfection" policy dated 12/2023 revealed it did not specify what to use for mopping the floor after discharge. It stated, "Damp mop the floor starting at the far side of room and work toward the doorway."	C1208		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted from 4/23/24 through 4/25/24. Bennett County Hospital was found in compliance.	E 000		

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

Shandel Anson | CEO | 5/14/2024

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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	431314	A. BUILDING **01 - MAIN BUILDING** B. WING _____	04/23/2024

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/23/24. Bennett County Hospital and Nursing Home - CAH was found not in compliance with 42 CFR 485.623 (d) (1) requirements for Critical Access Hospitals. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222, K225, K347, K363, K522, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	Exit signs marking the cross-corridor egress doors in the two hour fire-rated wall between the hospital and the former Nursing Home will be removed by the Maintenance Supervisor so that these doors are no longer designated as exits. Staff working in the Wellness Center (former Nursing Home area) will be advised by the Maintenance Supervisor to utilize the numerous other existing exits doors that are equipped with interior crash bars to allow exit from the interior even when locked. All designated Exit doors will be monitored weekly by the Maintenance Supervisor to insure proper functioning when locked and findings reported to the facility QAPI Committee monthly until 100% compliance is achieved for three consecutive months, then proceed per committee recommendations.	6/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shandel Andon	CEO	5/14/2024

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the provider	K 222		

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K 222	Continued From page 2 failed to provide egress doors as required at one location (hospital to nursing home corridor). Findings include: 1. Observation on 4/23/24 at 1:15 p.m. revealed the cross-corridor egress doors in the two-hour fire-rated wall between the hospital and the former nursing home was equipped with magnetic lock hardware. Interview with the maintenance supervisor at the time of the above observation revealed the magnetic locks were activated by one of three 'active shooter' panic buttons located at the hospital nurses' station, the clinic reception desk, and computer room. He added the locks were automatically activated to lock at 5:00 p.m. daily. A key fob would be required to pass through either door. The doors were both marked as required EXITs with illuminated signs. The magnetic locks when activated nightly would prevent egress from any individual without a key fob. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He stated he was new in the position in the last six months and that there had not been any testing of the magnetic locking doors to verify that operation. Failure to provide egress doors as required increases the risk of death or injury due to fire. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 225	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures	K 225	Maintenance Supervisor adjusted spring hinges on this ninety- minute fire rated door at the nurses station on 5/7/2024 to insure that door will close properly.	5/7/2024

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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
K 225	Continued From page 3 Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain a separation one of one randomly observed stair enclosure to the second floor and lower level (corridor door was not closing to latch). Findings include: 1. Observation on 4/23/24 at 10:40 a.m. revealed the ninety-minute fire-rated door at the nurses station to the stair enclosure to the second floor and basement was equipped with spring hinges. Testing of the door at the time of the above observation revealed the door would not close to latch with the spring hinges. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. The deficiency had the potential to affect 100% of the smoke enclosure occupants.	K 225	Continued from page 3: Checking this door for proper closing will be added to the weekly "Walk through checklist" for monitoring by the CNO or designee and Maintenance Supervisor or designee. Results will be reported to facility QAPI Committee monthly by Maintenance Supervisor or CNO to insure continued compliance at 100%.	
K 347	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1, 19.3.4.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain corridor smoke monitoring of that area for one randomly observed area (south	K 347	Maintenance Supervisor installed a battery operated smoke detector device in the south end of the patient wing on 5/7/2024. Testing of this device will be added to the weekly "walk through checklist" and monitored weekly by the CNO or designee and the Maintenance Supervisor or designee, to insure proper functioning of the device. Results will be reported to QAPI Committee monthly by CNO or Maintenance Supervisor to insure continued 100% compliance.	5/7/2024

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	431314	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/23/2024**

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K 347	Continued From page 4 end of the patient wing) as required. Findings include: 1. Observation on 4/23/24 at 10:50 a.m. revealed the south end of the patient wing was separated at the former palliative care area by a pair of cross-corridor doors. The area was open to the required EXIT but was not equipped with any smoke detection device. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 347		
K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363	A. Items stored in Room 108 that were blocking the door from closing were removed by the CNO on 4/24/2024 and staff will be instructed by CNO at All Staff meeting scheduled for 5/22/2024 that all doors must remain unobstructed. Checking for obstruction of corridor doors will be added to the facility weekly "walk through checklist" and monitored by the CNO or designee and findings reported monthly to facility QAPI Committee by CNO to insure continued 100% compliance.	4/24/2024

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K 363	Continued From page 5 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain impediment-free closing for one randomly observed corridor door (room 108) as required. Findings include: 1. Observation on 4/23/24 at 10:55 a.m. revealed the corridor door to patient room 108 was blocked by a Bowman dispenser (holding single-use gloves of various sizes). The room was being used to store unused walkers and wheelchairs and was full. There was no room to move the Bowman dispenser into the room. The corridor door would not be able to be closed without moving the dispenser unit. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363	Continued from page 5: B. Deadbolt lock was removed from the shower area corridor door of Room 110 (Provider overnight room) by the Maintenance Supervisor on 5/7/24 and positive latching hardware installed. Checking all corridor room doors for proper latching hardware will be added to the "weekly walk-through checklist" and monitored by CNO or designee and Maintenance Supervisor or designee. Maintenance Supervisor or CNO will report findings monthly to QAPI committee to insure 100% continued compliance.	5/7/2024

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K 363	Continued From page 6 B. Based on observation and interview, the provider failed to maintain positive latching hardware for one randomly observed corridor door (room 110 shower room) as required. Findings include: 1. Observation on 4/23/24 at 11:00 a.m. revealed the patient room 110 had two corridor doors. One door was to the provider-used main room and one door was from the shower area to the corridor. The shower area corridor door was equipped with a deadbolt which was not a positive-latching device. The room would not be separated from the corridor unless the door was closed and then the deadbolt turned into the strike plate. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		
K 522	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This STANDARD is not met as evidenced by:	K 522	A dedicated combustion (fresh) air duct will be installed by the Maintenance Supervisor in the outer wall of the Laundry room where the two gas dryers are located to take air in for combustion from outside. Monitoring for proper working of this air duct will be the responsibility of the Maintenance Supervisor and will be added to the "weekly walkthrough checklist." Maintenance Supervisor or designee will report findings monthly to QAPI Committee to insure 100% continued compliance.	5/9/2024

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K 522	Continued From page 7 Based on observation and interview, the provider failed to maintain combustion (fresh) air in one randomly observed laundry area. Findings include: 1. Observation of the two Huebsch 165,000 btu input commercial propane gas-fired dryers in the laundry room on 4/23/24 at 10:30 a.m. revealed the following: a. There was no dedicated combustion (fresh) air ductwork provided for the operation of the two propane gas-fired commercial clothes dryers. b. A manually operated window is not acceptable for use as a combustion (fresh) air source for fuel-fired equipment. c. The corridor door to the laundry room may not be used as a source of combustion air for the dryers. This door is to be closed at all times to maintain fire separation of the laundry room. Interview with the maintenance supervisor at the time of the above observations confirmed those findings. The deficiency affected one of several requirements for fuel-fired devices.	K 522		
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923	Combustible materials and oxygen concentrators were removed from the oxygen storage room by Maintenance Supervisor on 4/26/2024. All staff will be educated not to store anything other than oxygen cylinders and oxygen related non-combustible equipment in the Oxygen Storage Room by the CNO at an All-Staff meeting scheduled for 5/22/2024 and a reminder sign will be placed by the door on 5/13/2024.	5/13/2024

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K 923	Continued From page 8 gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure combustible items and oxygen concentrators were not stored within five feet of the oxygen cylinders in the storage room. Findings include: 1. Observation on 4/23/24 at 11:15 a.m. revealed combustible materials and four oxygen concentrators were found to be stored adjacent to and within five feet of oxygen cylinders in the oxygen storage room. The minimum five feet of	K 923	Continued from page 8: Checking of Oxygen Storage Room will be added to the "weekly walk-through checklist" for monitoring by the CNO or Maintenance Supervisor or designee and findings reported monthly to QAPI Committee to insure 100%	

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K 923	Continued From page 9 separation between combustibles and oxygen storage was not maintained as required in this area. Interview with the maintenance supervisor at the time of the above observation confirmed that finding. The finding violated one of several requirements for the storage of oxygen.	K 923		

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	10549S	A. BUILDING: _____ B. WING _____	04/25/2024

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S 000	Compliance/Noncompliance Statement A licensure health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 4/23/24 through 4/25/24. Bennett County Hospital was found not in compliance with the following requirement: S130	S 000		
S 130	44:75:02:07 Food Service Food service must be provided by a facility or food service establishment licensed in accordance with SDCL chapter 34-18, that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§ 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95. A facility of seventeen beds or more shall have a mechanical dishwasher. The facility shall have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on testing, review of manufacturer's instructions for use, and interview, the provider failed to mix sanitizer solution for the storage of wiping cloths in the kitchen according to manufacturer's instructions for two of two buckets of sanitizer. Findings include: 1. Testing on 4/23/24 at 11:15 a.m. of the sanitizer solution for the storage of wiping cloths in the kitchen revealed the sanitizer solution in both buckets tested 1000 parts per million (ppm) quaternary ammonia. 2. The test strip only tested up to 1000 ppm	S 130	Dietary Manager D was instructed by Chief Executive Officer (CEO), who was the former Infection Control Preventionist RN, on 5/8/24 to follow manufacturer's instructions for use of any/all sanitizer products to insure proper solution ratio and effectiveness of product. A policy for use of Dietary Sanitizing Solutions is developed by the CEO. It will be the responsibility of the Dietary Manager to insure that all present and future dietary workers are educated to this policy. This will be monitored by the Chief Nursing Officer (CNO), or designee, using test strips to test buckets of wiping solutions two times per week for accuracy and results reported to facility Quality Assurance/Performance Improvement Committee (QAPI) monthly by the CNO or designee until 100% compliance is achieved for 3 consecutive months, then proceed per committee recommendations per findings.	6/9/2024

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

Shandel Anson — CEO — 5/14/2024

STATE FORM 6899 3W5611 If continuation sheet 1 of 2

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S 130	Continued From page 1 Review of the manufacturer's instructions for use for the sanitizer revealed it was not to exceed 400 ppm quaternary ammonia when used as a sanitizer in eating establishments. Interview on 4/23/24 at 11:20 a.m. with the certified dietary manager D revealed she agreed the sanitizer solution was too strong and was not mixed to the manufacturer's instructions for use.	S 130		