STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	432002	A. BUILDING _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL - SOUTH DAKOTA	1305 WEST 18TH 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 complaint health survey for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals was conducted from 5/21/24 through 5/23/24. Area surveyed included quality of care/treatment. Select Specialty Hospital-South Dakota was found not in compliance with the following requirements: A385 and A747.	A 000	To ensure wound care orders are obtained and wound assessments and treatment are completed in accordance with policies WC II-7, Wound Documentation, and WC II-2, Wound Assessment, the Director of Quality Management (DQM), Chief Nursing Officer, or designee, will provide education to all registered nurses and the wound care nurse on the initiation of wound treatment per physician orders and/or per protocol/algorithm upon admission. Education will be completed no later than July 2, 2024 As of July 3, 2024 any staff that has not completed this education will do so prior to working their next scheduled shift. The DQM, or designee will be responsible for monitoring staff participation in education. Monitoring will continue weekly until 100% of staff are compliant. Compliance with the above plan will be monitored by Director of Quality Management, Chief Nursing Officer, and/or designee, by monitoring all patient admissions to ensure wound care orders have been obtained and followed. This will continue until 90% compliance has been achieved and sustained. At that time, monitoring will be part of the hospital's ongoing Quality Assurance Performance Improvement (QAPI) Plan via weekly audits. Findings will be reported monthly by the DQM to the QAPI Team and quarterly to the Organization Improvement Committee (OIC), Medical Executive Committee (MEC) and Governing Board (GB). Staff members who are noted to be non-compliant will be subject to disciplinary action, up to and including termination, per Human Resources policies and procedures. The Chief Nursing Officer is ultimately responsible for ensuring the plan of correction is implemented and that compliance is achieved and maintained. The hospital will be in full compliance with the above date by July 2, 2024	July 2, 2024
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: A. Based on record review, interview, and policy review, the provider failed to ensure an order was obtained for the daily wound care provider for one of one sampled patient (3) who had drain site wounds. Findings include: 1. Record review of patient 3's electronic medical record (EMR) revealed: *On 4/22/24 at 11:34 a.m. patient 3 had been admitted with a diagnosis of: -Acute respiratory failure, cerebral vascular accident (CVA), aortic valve replacement, atrial fibrillation (irregular heart rhythm), deep venous thrombosis (DVT). *On 4/22/24 at 8:24 p.m. an initial nursing assessment completed by registered nurse (RN) D revealed: -Patient 3 had four drain site wounds to his upper abdomen. -RN D had measured and photographed the	A 385		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 6/27/24

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 385	Continued From page 1 wounds and provided wound care that had included iodoform packing to each drain site, and then covering with a silicone dressing. --This assessment by RN D had been performed nine hours after patient 3's admission. *On 4/23/24 at 8:00 a.m. and 8:34 p.m. documentation indicated patient 3's dressing was a non-adherent dressing. *On 4/24/24 at 8:00 a.m. and 8:00 p.m. documentation indicated patient 3's dressing was a non-adherent dressing. *On 4/25/24 at 7:43 a.m., 8:00 p.m., and 4/26/24 at 8:00 a.m. documentation indicated patient 3's wounds were open to air (not covered with a dressing). *On 4/26/24 at 12:30 p.m. documentation by RN G indicated that patient 3's wounds had been measured and wound care was provided that had included iodoform packing to each drain site, and then coving the wound with a silicone dressing. *There had not been any order for daily dressing changes for patient 3 entered in his EMR. *On 4/30/24 patient 3 had a rapid response (a decline in a patient's health requiring specialty health services) due to his declining health status. 2. Interview on 5/22/24 at 9:00 a.m. with RN wound care nurse B regarding wound care for patient 3 revealed: *She had received the order for his wound care evaluation on 4/29/24. *She completed the evaluation of patient 3 on 5/1/24 and clarified the orders that had been placed on 4/26/24. -She worked Monday through Friday and on off hours house supervisor nurses would have completed wound care. *Patients have wound care evaluated completed within 24 hours of receiving an order.	A 385		

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A 385	Continued From page 2 3. Interview on 5/22/24 at 2:25 p.m. with medical doctor (MD) C regarding patient 3's history and physical including his wounds revealed: *He did not remember receiving any information on patient 3's wounds and his wound care. *He would have put wound care orders in the EMR system with the assistance of the wound care nurse and skin team. *He had not documented patient 3's wounds in his history and physical. *He had not assessed patient 3's wounds. 4. Interview on 5/22/24 at 3:34 p.m. with MD K regarding wound care revealed: *Patient 3 had developed bacteremia and required a rapid response intervention on 4/30/24. *He could not confirm or deny that patient 3's delay in wound care could have contributed to his rapid response on 4/30/24. *He stated proper documentation and sign off are very important for good patient care. 5. Interview on 5/22/24 at 3:51 p.m. with RN D regarding wound care for patient 3 revealed: *She had first assessed patient 3 on 4/22/24 on during the night shift. *She removed his dressing and packing that he was admitted with, documented his wounds, and packed them with iodoform gauze and covered the wounds with a silicone dressing. *RN D reviewed patient 3's orders and noticed there had not been any orders in his EMR for his wound care. *She had passed on her wound care to the morning shift during report and then she was off work for a few days. *If a patient had arrived after hours and on a	A 385		

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A 385	Continued From page 3 weekend when the wound nurse was not working, house supervisors would have provided wound care until the wound nurse returned. *She had been concerned that patient 3 had not received any wound care 4/22/24 until 4/26/24. 6. Interview on 5/23/24 at 9:00 a.m. with RN G regarding patient 3's wound care revealed: *She had completed a dressing change to patient 3's drain sites on 4/26/24. *She had found a transfer sheet from the sending provider with instructions for patient 3's wound care and dressing change they had provided. *RN G had informed the hospitalist that day and received an order for daily and as needed dressing changes to patient 3's drain sites. 7. Review of the provider's July 2021 Admission of patient to the unit revealed: *" A registered nurse will perform the initial assessment of the patient upon admission to the nursing unit and place the appropriate identification bracelets on the patient." *" Initial assessment should be done within the first 8 hours of admission." B. Based on observation, and interview, the provider failed to ensure maintained visualization of dialysis catheters by two of two observed contracted RN (F and H) had maintained visualization for two of two patients (7 and 8) during their dialysis treatment. Finding include: 1. Observation and interview on 5/22/24 at 10:30 a.m. with RN F during patient 7's dialysis treatment revealed: *RN F had been sitting at a portable computer desk. *Patient 7 had her left hand elevated on pillows.	A 385	To ensure dialysis providers maintain visualization of dialysis catheters, in accordance with the contracted dialysis service policy Treatment Assessment and Care, the Director of Quality Management, or designee, will provide education to all contracted dialysis clinicians who provide care to Select patients in regards to maintaining visualization of dialysis catheters. To ensure completion of competencies on contracted dialysis staff, including observation of dialysis providers maintaining visualization of dialysis catheters the Director of Quality Management, or designee, will complete yearly competencies with all contracted dialysis staff who provide services to Select dialysis patients. Education and competencies will be completed no later than June 17, 2024 As of June 18, 2024 any staff that has not completed this education will do so prior to working their next scheduled shift. The DQM, or designee will be responsible for monitoring staff participation in education. Monitoring will continue weekly until 100% of staff are compliant. Compliance with the above plan will be monitored by the Director of Quality Management (DQM), or designee, by visually auditing line of sight of dialysis providers daily while patients are receiving dialysis. This will continue until 90% compliance has been achieved and sustained. At that time, monitoring will be part of the hospital's ongoing QAPI Plan via monthly audits Findings will be reported monthly by the DQM to the QAPI Team and quarterly to the Organization Improvement Committee (OIC), Medical Executive Committee (MEC) and Governing Board (GB). Contracted dialysis staff members noted to be non-compliant will be reported to the Dialysis Manager for follow-up. The Chief Nursing Officer is ultimately responsible for ensuring the plan of correction is implemented and that compliance is achieved and maintained. The hospital will be in full compliance with the above date by July 2, 2024	

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A 385	Continued From page 4 *RN F had not been able to visualize patient 7's dialysis catheter due to patient 7 moving the pillow. *After RN F was asked about dialysis catheter visualization, she adjusted patient 7's pillow and then asked the surveyor if that was good enough. *She was unsure of what she needed to have constant visualization of. 2. Observation and interview on 5/22/24 at with RN H during patient 8's dialysis treatment revealed: *Patient 8's catheter and dialysis connection sites had been covered by a part of the absorbent pad on his chest. *RN H stated she had been able to visualize patient 8's catheter and connection site while seated at her portable computer desk. *RN H got up from her portable computer desk and uncovered the non-visible portion of the dialysis catheter. *She stated she had recently obtained vital signs on patient 8 and the absorbent pad had covered the catheter and connection site for only a few minutes. 3. Interview on 5/23/24 at 4:15 p.m. with director of quality management E regarding competencies (demonstration of fundamental skills) on contracted RNs revealed: *She had only performed competencies on contracted staff for infection control practices. *They had not received any dialysis completed competencies for the contracted nurses from the contracted service. *Their expectation that competencies are completed annually with contracted nurses by the contracted service that provided dialysis. *She agreed that constant visualization of	A 385		

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A 385	Continued From page 5 catheters during dialysis was very important for patient safety. A request for a policy for contracted dialysis had been made prior to exit. The provider did not have a policy.	A 385	To ensure glucometer cleaning in accordance with policy WT-01, Glucose Monitoring Accu-Chek Inform II, the Director of Quality Management, or designee, will provide education to all registered nurses, Student Nurse Techs and Nursing Assistants on proper glucometer cleaning. Education will be completed no later than July 2, 2024. As of July 3, 2024 any staff that has not completed this education will do so prior to working their next scheduled shift. The DQM, or designee, will be responsible for monitoring staff participation in education. Monitoring will continue weekly until 100% of staff are compliant. Compliance with the above plan will be monitored by the Director of Quality Management (DQM), or designee, by observing each glucometer twice per day for cleanliness. This will continue until 90% compliance has been achieved and sustained. At that time, monitoring will be part of the hospital's ongoing QAPI Plan via weekly audits. Findings will be reported by the DQM monthly to the QAPI Team and quarterly to the Organization Improvement Committee (OIC), Medical Executive Committee (MEC) and Governing Board (GB). Staff members who are noted to be non-compliant will be subject to disciplinary action, up to and including termination, per HR policies and procedures. The Chief Nursing Officer is ultimately responsible for ensuring the plan of correction is implemented and that compliance is achieved and maintained. The hospital will be in full compliance with the above date by July 2 2024.	July 2, 2024
A 747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: A. Based on observation, interviews, and policy review, the provider failed to ensure two of four observed glucometers had been cleaned and disinfected properly prior to patient use. Findings include: 1. Observation on 5/21/24 at 9:30 a.m. of one glucometer docked outside of room 2475 revealed it had visible blood near the glucometer strip insertion site and on the backside of the machine.	A 747		

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A 747	Continued From page 6 2. Interview on 5/21/24 at 9:33 a.m. following the above observation with registered nurse (RN) D regarding the visible blood on the glucometer revealed: *The glucometer having been in the docking station meant it had been cleaned, disinfected, and ready for patient use. *She: -Confirmed there was visible blood on the glucometer in the docking station. -Agreed that it was not cleaned and disinfected prior to docking it in the station. -Would have someone clean and disinfect it right away. 3. Observation on 5/21/24 at 11:08 a.m. at the nurse's station located in the north hallway revealed a glucometer in the docking station that had visible blood on the front, sides, and back of the machine. Interview on 5/21/24 at 11:30 a.m. with director of quality management (DQM) E and chief nursing officer (CNO) I regarding the docked glucometers revealed: *After use, the glucometers should have been cleaned and disinfected with a purple top disinfectant wipe per the manufacturer's recommendations and placed in the docking station. *When the glucometers were in the docking station, they were considered by staff as cleaned, disinfected, and ready for patient use. 4. Observation on 5/22/24 at 8:22 a.m. of the same docked glucometer at the nurse's station located in the north hallway again revealed visible blood on the same areas as observed on 5/21/24 at 11:08 a.m.	A 747		

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A 747	Continued From page 7 5. Interview on 5/22/24 at 8:37 a.m. with DQM E regarding the above observation revealed: *The docked glucometer should have been cleaned, disinfected, and ready for patient use. *She agreed that the above glucometer had visible blood on it and it and required cleaning and disinfection. *She would clean and disinfect it immediately. 6. Interview on 5/22/24 at 8:40 a.m. with RN A regarding docked glucometers revealed he stated: *"If the glucometer is in the docking station it is clean and ready for patient use." *"Glucometers are cleaned with a purple top wipe and the contact time is two minutes." 7. Review of the provider's October 2023 Cleaning: Environment, Patient Equipment and Medical Devices policy revealed: *"If it is unclear where or not the equipment is clean, it must be cleaned before use. *The standard of cleanliness is that all parts of the equipment including the underneath be visibly clean with no blood and body substances, dirt, debris, dust, adhesive tape, stains or spillage." B. Based on observation, interviews, and monthly infection control rounding tool review, the provider failed to ensure wound care for one of one sampled patient (3) had been performed using a clean technique by one of one observed registered nurse (RN) B. Findings include: 1. Observation on 5/21/24 at 9:54 a.m. with RN B while performing wound care to patient 3 revealed she:	A 747	To ensure wound care is completed using clean technique, the Chief Nursing Officer, or designee, will provide education to all registered nurses and the wound care nurse on the following: • Wound care dressing supplies to be placed on a clean barrier; • Hand hygiene being performed when moving from dirty to clean; • Appropriate cleaning of re-usable devices after use and prior to storage with clean supplies Education will be completed no later than July 2, 2024. As of July 3, 2024 any staff that has not completed this education will do so prior to working their next scheduled shift. The DQM, or designee, will be responsible for monitoring staff participation in education. Monitoring will continue weekly until 100% of staff are compliant. Compliance with the above plan will be monitored by Director of Quality Management (DQM), Chief Nursing Officer, and/or designee, by monitoring 3-5 instances of wound care daily. This will continue until 90% compliance has been achieved and sustained. At that time, monitoring will be part of the hospital's ongoing Quality Assurance Performance Improvement (QAPI) Plan via weekly audits. Findings will be reported by the DQM monthly to the QAPI Team and quarterly to the Organization Improvement Committee (OIC), Medical Executive Committee (MEC) and Governing Board (GB). Staff members who are noted to be non-compliant will be subject to disciplinary action, up to and including termination, per Human Resources policies and procedures. The Chief Nursing Officer is ultimately responsible for ensuring the plan of correction is implemented and that compliance is achieved and maintained. The hospital will be in full compliance with the above date by July 2, 2024	

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A 747	Continued From page 8 *Washed her hands and put on a pair of clean gloves. *Removed the dressing and packing from four drain sites located on patient 3's abdomen. *Removed her gloves, washed her hands, and put on a new pair of clean gloves. *Placed dressing supplies next to the sink and the patient's clothing without a clean barrier under the wound care supplies. *Irrigated the drain sites with normal saline and wiped them with gauze. *Removed her gloves, washed her hands, and put on a pair of clean gloves. *She opened a sterile Q-tip, layed it on the bedsheet, cut a string of iodoform gauze, and placed the scissors on the bedsheet. *She then used that same Q-tip to pack one drain site with iodoform gauze. *She repeated that same process three more times using the same technique all with those same gloved hands. *With those same gloves she applied a silicone dressing over four drain sites, removed the gloves, and washed her hands. *She then placed the scissors she had used in a locked drawer of a cabinets in the patient's room that contained clean supplies. -She had not cleaned the scissors prior to placing them in that drawer. 2. Interview on 5/22/24 at 2:20 p.m. with RN B regarding a clean surface for wound care supplies revealed she: *Stated she had wiped the surface near patient 3's sink with a purple top disinfectant wipe before setting wound care supplies down on it and prior to the surveyor arriving. *Considered a clean workspace to be dry, not visibly dirty, and by using a clean sheet,	A 747		

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A 747	Continued From page 9 disposable pad, or towel under the supplies. *Considered the area by the sink to be clean workspace if it had been wiped with a purple wipe. *Confirmed she had placed the scissors used to cut the iodoform dressing back into the drawer with other clean wound care supplies without cleaning it. *Remembered receiving education regarding contaminated equipment must be cleaned and stored appropriately, and to designate a clean area for wound care supplies. 3. Interview on 5/22/24 at 4:13 p.m. with DQM E regarding proper handing, storage of wound care supplies, and monthly infection control rounds tool revealed she: *Stated the patient's bed sheet would not have been considered a clean surface. *Confirmed a disposable pad or a clean towel should have been used as a barrier. *Would have expected the monthly infection control rounds tool as a policy. 4. Review of the provider's monthly infection control rounds tool revised June 2022 revealed, "Clean/Sterile items are not stored within 3 ft of the sink."	A 747		