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	430005	A. BUILDING _____ B. WING _____	C 10/23/2024

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PRAIRIE LAKES HOSPITAL	401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 482, Subpart A - D; and Subsection 482.66, requirements for Hospitals was conducted from 10/21/24 through 10/23/24. Prairie Lakes Hospital was found not in compliance with the following requirements: A505, A724, A749, and A940. A complaint health survey for compliance with 42 CFR Part 482, Subpart A - D; and Subsection 482.66, requirements for Hospitals was conducted from 10/21/24 through 10/23/24. Area surveyed was pharmaceutical services. Prairie Lakes Hospital was found in compliance.	A 000		
A 505	UNUSABLE DRUGS NOT USED CFR(s): 482.25(b)(3) §482.25(b)(3) - Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two expired sterile water bags and five 0.9% intravenous (IV) solution bags used for irrigation in one of one fluid warmers were not available for patient use. Findings include: 1. Observation and interview on 10/21/24 at 2:30 p.m. with director of surgical services A in the sterile core of the operating room (OR) revealed: *A fluid warmer contained irrigation and IV solutions for patient use. *Irrigation solutions had a sticker affixed with the date the solutions had been placed into the fluid warmer. *A fluid warming guideline had been posted on	A 505	**A505 Corrective Action** 1) The Director of Surgical Services (D-SS) removed the outdated IV and irrigation fluids from the operating room (OR) fluid warmer on October 21, 2024, and replaced with appropriately dated and labeled solutions. 2) The D-SS and the Director of Anesthesia reviewed OR fluid warmer contents on November 5, 2024, and determined that IV fluids do not need to be stored in the warmer as anesthesia has an alternate means for immediate warming of IV fluids. Only irrigation solutions will be kept in the OR fluid warmer; IV fluids were removed. 3) On November 5, 2024, the D-SS placed a document on the warmer that outlines the temperature guidelines for the OR fluid warmer, the outdate timeline for fluids in the warmer, and the process for checking outdates, and expected actions when items are removed after fourteen (14) days in the warmer. An email summary will be sent to OR staff outlining the changes and guidelines for the fluid warmer. OR staff will sign to attest to receiving the emailed education.	12/02/2024

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

John Allen John Allen CEO 11/08/2024 11/14/2024

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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A 505	Continued From page 1 the fluid warmer to instruct staff on the labeling and expiration date requirements of solutions used for irrigation. -IV bagged solutions for irrigations were good for up to 14 days in the warmer. *Two sterile water irrigation solutions had expired. -One bag had been labeled 8/6/24. -One bag had been labeled 10/2/24. *Five 0.9% normal saline irrigation solutions had expired. -Four bags had been labeled 9/12/24. -One bag had been labeled 4/24. *Director of surgical services A had stated staff should have rotated and removed expired items as part of their duties. *He agreed the irrigation solutions had expired and were available for patient use. Review of the provider's undated fluid warming guidelines revealed: *"IV bagged solutions for irrigation (with plastic pouch over pouch intact): -Good in warmer for up to 14 days. -Label plastic over pouch with date that the solution had been placed in the warmer." Review of the provider's 4/24 Warmers policy revealed: *"Monitoring and maintenance of warming cabinets containing patient use items will be done regularly to ensure that temperatures are in established ranges and warmed patient use items are not expired. *Contents and content manufacturer recommendations for temperature based on intended use and any pertinent expiration date of warmed contents; -Solution stability may vary according to fluid composition and storage containers. Contact the	A 505	A505 (continued from Page 1) 4)The D-QRM updated the organization's Warmer Policy to reflect that temperature and expiration dates of contents of the fluid warmers in non-24/7 departments would be done during regular hours of operation (Monday-Friday, excluding holidays). 5) Starting November 11, 2024, an OR staff member will log the temperature of the fluid warmer and confirm no outdated inventory in the fluid warmer daily Monday through Friday (excluding Holidays). Any outdated fluids will be removed and replaced accordingly at that time and BioMed will be contacted for any temperatures outside of the expected range. **A505 Performance Monitoring** 1) The D-SS or designee will audit the fluid warmer log weekly on Mondays for three (3) months to ensure that once daily outdate and temperature checks are being completed 100% of the time on a Monday through Friday basis (excluding holidays). Audit results will be reported by the D-SS to the Director of Quality and Risk Management (D-QRM) and the QAPI Committee monthly. The QAPI Committee will determine if compliance has been met as evidenced by 100% daily checks being completed; or if audit will continue weekly until compliance has been met. 2) The D-SS or designee will audit staff education attestations regarding the changes to use and guidelines around the OR fluid warmer. This audit will occur weekly until 100% of OR staff have completed the attestation. Audit results will be reported monthly by the D-SS to the QAPI Committee. The QAPI Committee will determine if compliance has been met as evidenced by 100% of staff completing attestation; or if audit will continue weekly until compliance has been met	

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A 505	Continued From page 2 manufacturers of the solution being used to determine the proper length of time for fluid warming. Calculate the length of safe storage according to the highest temperature in the range. *Temperature ranges and any pertinent content expiration guidelines will be posted on warming cabinets. *Cabinet temperature and expiration dates of contents will be monitored daily and recorded on a log or electronic recoding system."	A 505		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. 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 monthly testing for Automated External Defibrillators (AED) followed the manufacturer's monthly testing protocol for eight of eight locations (cafeteria, main entrance, medical office building conference center, dialysis, outreach clinic, and the specialty clinic areas (physical therapy, cardiology, and urology) for the safety of patients, staff, and visitors. Findings include: 1. Observation on 10/21/24 at 12:45 p.m. of the AED in the main hospital entrance revealed no indication of the last monthly inspection. No date was observed on the case indicating an inspection. Interview and review on 10/23/24 at 1:57 p.m.	A 724	**A724 Corrective Action** 1) Following review of the AED IFU, a BioMed staff member completed readiness testing of the AEDs (total of 8) located in the cafeteria, main entrance, medical office building conference center, dialysis, outreach clinic, and the specialty clinic areas (physical therapy, cardiology, and urology) on October 24, 2024 as directed by the IT Services Manager (IT-SM). 2) All BioMed staff will review the IFU for the AEDs and sign an attestation acknowledging the review and education. Education will be logged and audited for completion. 3) AEDs BioMed staff will ensure monthly readiness testing requirements on the facility's AEDs are completed based on the equipment IFU. Some testing will be manual checks and some automated – see #3). 4) Following directions in the AED IFU, BioMed staff will complete set up for the six (6) AEDs with wi-fi capability for automated self-testing. The automated testing records AED readiness daily, weekly, and monthly. Successful wi-fi testing set up will be evidenced by the auto-generated reports from LIFENET that will be received and monitored by BioMed Staff (monthly at minimum); BioMed will take applicable action if there is a LIFENET alert of a test failure and log any actions taken.	12/02/2024

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A 724	Continued From page 3 with the chief nursing officer (CNO) K regarding the provider's Code Blue/Emergency Care policy dated May 2024 confirmed: *AEDs were maintained in the above listed locations. -She was not sure which staff member(s) was responsible for the AED in the main entrance lobby or the cafeteria. *The department directors were responsible for AED maintenance, and they had not conducted monthly maintenance checks. *Biomedical conducted battery checks every six-months. *She was not sure if the AEDs could have been connected wirelessly for monthly monitoring and would check on that. Interview on 10/23/24 at 3:35 p.m. with CNO K confirmed the AEDs in the above listed locations were not wirelessly connected for monitoring and should have been checked per the manufacturer's IFU. Review of the manufacturer's Maintaining a State of Readiness instruction for use revealed: *"Device readiness should be verified at least each month. If your device has wireless access to LIFELINKcentral AED Program Manager or LIFENET System, you can verify the device status remotely. If your device does not have wireless access, you must check the Readiness indicator on the devices." *"Verifying Readiness for Devices with Wireless Access. The device performs automatic self-tests daily, weekly, monthly, and every time you turn it on. If the automatic self-tests are successful, the device checks in to LIFELINKcentral AED Program Manager or LIFENET System once each month and reports that it is READY."	A 724	A724 (continued from page 3) 5) The two (2) AEDs that are not Wi-Fi compatible will be manually readiness checked monthly by BioMed until the new (ordered on October 30, 2024) wi-fi compatible AEDs arrive and are installed. Once the new AEDs arrive, BioMed will set them up for automated testing as described in #3 above. 5) BioMed staff will continue to check the AED batteries in all AEDs every six (6) months. At that time, they will also ensure there are no outdated or near-term outdating supplies (such as the AED pads) in the AED case; and replace accordingly at that time. **A724 Performance Monitoring** 1) The IT-SM will audit each AED testing logs/reports monthly for six (6) months to ensure 100% completion; this will indicate the AED(s) were tested for readiness (whether manually tested or via automated wi-fi testing). Audit findings will be reported by the IT-SM to the CIO and the QAPI Committee monthly. The QAPI Committee will determine if compliance has been met as evidenced by 100% completion/availability of monthly reports; or if audits will continue monthly until compliance has been met. 2) The IT-SM will audit education attestations from BioMed staff indicating their review and education about AED readiness testing and wifi set up as outlined in the AED IFU. The audits will occur weekly until 100% of BioMed staff have attested. Audit results will be reported monthly by the IT-SM to the CIO and the QAPI Committee. The QAPI Committee will determine if compliance has been met by 100% completion of attestation forms; or if audits will continue monthly until compliance has been met.	

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A 724	Continued From page 4 *"If your device is wirelessly connected to a LIFELINKcentral AED Program Manager or LIFENET System account and the device fails to check in at least once each month, an email notification is sent to your organization's designated person. The email describes which of the following actions you need to perform: Replace electrode tray, Replace battery, Contact qualified service personnel." *If the devices does not have wireless capability or is unable to automatically connect to LIFELINKcentral AED Program Manager or LIFENET System ...You should check the Readiness indicator on the device at least once each month. If the device is not ready, the Readiness indicator does not flash and an alert tone sounds every 15 minutes."	A 724		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observation, interview, and manufacturer's instruction for use (IFU), the provider failed to ensure: *Staff followed manufacturer's mixing instruction for use for the Prolystica and enzymatic cleaner. *Patient commode buckets were properly disinfected by one of one patient care technician (N). Findings include: 1. Observation and interview on 10/22/24 at 9:46	A 749	**A749 Corrective Action** 1) The Infection Prevention RN (IP-RN) completed education on October 22nd, 2024, with the Med/Surg (MSP), Critical Care (CCU) and Telemetry Unit (TU), and Emergency Department (ED) and Same Day Services (SDS) staff and techs on duty regarding the proper mixing of enzymatic cleaner, and the cleaning and disinfection of commode buckets. A plain language sign with cleaning and disinfection instructions was posted in the soiled utility rooms in the above noted locations regarding the commode buckets. 2) The IP-RN sent an email On October 22, 2024, outlining commode bucket cleaning and disinfecting instructions, including the plain language signage, to all department directors where commodes are utilized.	12/02/2024

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A 749	Continued From page 5 a.m. with senior director of inpatient services O in the critical care unit (CCU) soiled utility room revealed: *Two gray commode buckets turned upside down on the counter. *Patient care technicians (PCTs) were responsible for disinfecting the commode buckets. *There were no instructions posted for the commode disinfection process. -There was no PCT assigned for CCU today and she would have another PCT come and explain the disinfection process. *PCT N arrived at 9:52 a.m. to the CCU soiled utility room and explained her disinfecting process for the commode buckets as follows: -To clean the commode buckets three pumps of Prolystica (enzymatic cleaner) was put into the buckets. -The bucket was then filled halfway or all the way with water depending on how soiled they were. --Warm or cold water could have been used. --If extremely soiled she would have washed them out first in the hopper. -Once the bucket had been cleaned she wiped the outside with a Prime Sani-Cloth the wipes in the container with a purple top, and then turned upside down to dry. -The inside of the bucket was not wiped with a Prime Sani-Cloth or a Bleach Sani-Cloth. -The above-described process was how she had been taught. Interview on 10/22/24 at 10:40 a.m. with registered nurse (RN) infection prevention staff F and G revealed: *The process described above would not have disinfected the commode buckets. *Prolystica was an enzymatic cleaner and staff	A 749	A749 (continued from page 5) 3) On October 31, 2024, the IP-RN held a meeting Sodexo Environmental Services Managers and department heads where commode buckets are utilized to again discuss the cleaning and disinfecting processes for commode buckets and considerations for a transition to disposable, single patient use commode buckets. 4) On October 31, 2024, the Senior Director of Inpatient Services (D-IS) ordered single patient use, disposable commode buckets to trial for size/fit with our commodes. Fit was confirmed and an additional quantity was ordered. On or before December 7, 2024, the organization will transition to single patient use, disposable commode buckets. 5) The D-IS, Director of Emergency Department (D-ED), and D-SS or designees will complete staff education regarding the transition to disposable commode buckets and post signs in soiled utility rooms with notice to staff that commode buckets are single patient use. Education will be logged and audited for completion. **A749 Performance Monitoring** 1) The IP-RN, Infection Prevention Coordinator (IP-C), or designee will audit the utilization of disposable commode buckets by observing the soiled utility rooms at least once per day (7 days per week) for three (3) months on MSP, CCU, TU, SDS, and ED to ensure there are no commode buckets waiting to be or actively being cleaned/disinfected beyond single patient use. Audit findings will be reported by the IP-RN to the D-QRM and the QAPI Committee. The QAPI Committee will determine if compliance has been met as evidenced by 100% single use commode buckets; or if audits will continue daily until compliance is achieved.	

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A 749	Continued From page 6 had been educated to use Sani-cloth bleach wipes in the container with the orange top. *To prevent potential cross-contamination bleach wipes should have been used on the entire commode bucket. *Bleach wipes were effective against Clostridioides difficile (C. diff). *C. diff is a bacterium that can cause diarrhea and other intestinal conditions. *The hospital at times had patients that were admitted with C. diff. Review of the Prolystica manufacturer's IFU revealed: *This was an enzymatic presoak and cleaner detergent that could have been used for surgical instruments or medical devices in the manual cleaning process. *For manual cleaning: -"Fill the sink or basin with warm water to the appropriate level to fully immerse surgical instruments." -The dilution ratio was "1/8 to 1/2 fluid ounce per (1 to 4 ml [milliliter]) of warm water." --The water temperture should not have exceeded 130 degrees Fahrenheit. -"Clean for a minimum of 1 to 5 minutes." -"After cleaning, all surfaces should be thoroughly rinsed with warm water."	A 749	A749 (continued from page 6) 2) The IP-C or designee will audit the staff education log where staff acknowledge receipt of education on the change to disposable commode buckets. This audit will occur weekly until the education log demonstrates that 100% of staff on MSP, CCU, TU, SDS have received the education. Audit results will be reported monthly by the IP-C to the QAPI Committee. The QAPI Committee will determine if compliance has been met as evidenced by 100% of staff education is complete; or if audit will continue weekly until compliance has been met	
A 940	SURGICAL SERVICES CFR(s): 482.51 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the	A 940	**A940 Corrective Action** 1) On October 23, 2024, the Director of Radiology (D-R) coordinated with FM staff to measure water volumes of one- and two-gallon quantities into the left tub of the sink used in the echocardiogram room for mixing with Prolystica enzymatic cleaner and water line markings in the sink to allow for the appropriate volume of water for mixing with the Prolystica enzymatic detergent.	12/02/2024

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A 940	Continued From page 7 complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, interview, policy review, and review of manufacturer's instruction for use (IFU), the provider failed to ensure: *Proper concentration of Prolystica enzymatic detergents and water had been measured per manufacturer's IFU in two of two areas (decontamination and echocardiogram room). *All contaminated instruments containing blood and bodily fluids from two of two tables had been pretreated, wet, and transported in a sealed, leak proof container. *Sixteen of sixteen SafeGuide Over the Guidewire Esophageal Dilation System dilators had been stored per manufacturer's IFU. *Two of two endoscopes' reprocessing medivator's (disinfects endoscopes) reusable mesh disinfectant filters had been cleaned monthly per manufacturer's IFU. Findings include: 1. Observation and interview on 10/21/24 at 3:10 p.m. in the decontamination room with sterile processing technician C revealed: *A large sink used to rinse and soak contaminated instruments. *Within the large sink there had been a smaller container placed to the right where Prolystica enzymatic detergent was mixed with water to clean and brush surgical instruments. *She had stated the instructions were to mix ½ ounce (oz) of Prolystica per gallon of water. *The sink was to be filled with three gallons of water and 48 milliliters (ml) of Prolystica. *There had been no mark on the container to indicate three gallons of water. *She had confirmed there had been no	A 940	A940 (continued from Page 7) 2) On October 23, 2024, the cardiac sonographer modified the written procedure for mixing the Prolystica with the water, provided education to the one other sonographer that may also handle the TEE equipment, and posted the directions at the cleaning station. Attestation of education for the two (2) sonographers was logged and audited for completion. 3) On October 23, 2024, the D-R created and implemented a manual log to document the enzymatic soak/cleaning process for the TEE device. The log documents the date of the exam, patient account number, water temperature, acknowledgement of the sink water lines being visible, and the initials of the sonographer completing the log. 4) The D-SS posted the written procedure regarding mixing of Prolystica and will provide education to staff that work in the decontamination room regarding the importance of marking the plastic tub used in the decontamination room with water lines to ensure appropriate mixing of water and Prolystica enzymatic cleaner based on the IFU. The sticker or permanent marker line will be in place daily or replaced if needed. Education will be logged and audited for completion. 5) The D-SS ordered a stainless-steel tub to replace the current plastic tub used for mixing water and Prolystica enzymatic cleaner in the decontamination room. A stainless-steel tub will allow for more permanent marking (with stickers) of the appropriate water lines. 6) The D-SS created and implemented a manual log to be completed daily by sterile processing staff to attest that the waterline marking (sticker or permanent marker) was visible or replaced.	

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A 940	Continued From page 8 measurement on the container to properly measure the enzymatic detergent to water per manufacturer's IFU. Interview on 10/21/24 at 3:30 p.m. in the decontamination room with sterile processing department coordinator B confirmed: *There had been no mark on the container to properly measure the enzymatic detergent to water per manufacturer's IFU. *She stated, "We use stickers, but they just fall off." *There should have been a mark on the container to ensure proper measurement of enzymatic detergent to water. Observation and interview on 10/22/24 at 3:00 p.m. and on 10/23/24 at 8:25 a.m. with cardiac sonographer H of the echocardiogram room revealed: *There was a Philips washing tube and a bottle of Steris Prolystica Enzymatic Cleaner on the countertop to the left of the sink. *The provider cleaned the transesophageal echocardiogram (TEE) scopes in the room. *The provider's X8-2T TEE IFU policy was taped to the wall above the sink. *There was no line in the sink to fill the show how much water for mixing the enzymatic cleaner. *She stated there was not a line in the sink to ensure they were meeting the manufacturer's IFU for enzymatic chemistry dilution. *She hadn't measured the amount of water added to dilute the enzymatic solution. Review of the provider's 7/29/24 X8-2T TEE IFU policy stated to fill the sink 1/4th full with lukewarm water and add three pumps of the enzymatic pre-soak solution.	A 940	A940 (continued from Page 8) 7) The D-SS will coordinate the delivery of staff education around the transportation of surgical instrumentation using the *Cleaning and Transporting Instruments, OR* procedure contained in Lippincott's Procedures On-Line. Operating room nurses, surgical techs, and sterile processing techs will review the procedure and sign an attestation that they reviewed and understand the requirements. Education will be logged and audited for completion. 8) The D-SS will coordinate and oversee a staff return demonstration with operating room nurses, surgical techs, and sterile processing techs on the proper handling and transportation of contaminated instrumentation. Education will be logged and audited for completion. 9) The D-SS has ordered red bins (sealed, puncture resistant, and leak proof) with clasping lids that will be used for the appropriate transportation of all surgical instrumentation following a procedure; the D-SS will coordinate staff education with operating room nurses, surgical techs, and sterile processing techs regarding use of the bins (based on IFU) prior to implementation or staff use. Education will be logged and audited for completion. The bins will be put into use on their arrival to the facility (expected November 18, 2024). 10) The D-SS will develop a log for use by the receiving sterile processing tech to indicate who delivered each table (bins used and table cover initialed) following a surgical procedure, time it was delivered, and whether the instrumentation was handled and delivered in compliance within expected requirements.	

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	430005	A. BUILDING _____ B. WING _____	C 10/23/2024

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A 940	Continued From page 9 Review of the Steris Prolystica Enzymatic Presoak and Cleaner IFU revealed: *Fill the sink with warm water to the appropriate level to immerse surgical instruments. *"Dilute chemistry 1/8 to 1/2 fl. oz. per gallon (1 to 4mL per Liter) of warm water. 2. Observation and interview on 10/21/24 at 3:10 p.m. in the decontamination room with certified surgical technician D revealed: *Surgical instruments used during the operation had been separated and placed into different containers with no lids on them. *The containers had been placed on a table with wheels for transportation to decontamination and central processing (department where re-usable instruments are cleaned and repackaged). *The table and instruments had been moved out of the operating room (OR) and rolled to decontamination and central reprocessing area. *The needles and sharp objects had been separated and discarded separately. *All the used instruments were sprayed with a pre-klenz (pre-treatment gel) or placed in water prior to transporting to decontamination. *A large drape had been placed over the instruments in the containers. *A large red drape containing a biohazard label was then draped over the entire table containing the instruments. *The red drape covering the instruments was not sealed, leak proof, or puncture resistant. *She confirmed sealed, leak proof containers had not been used to transport contaminated surgical instruments. Observation and interview on 10/21/24 at 3:30 p.m. in the decontamination room with sterile	A 940	A940 (continued from Page 9) 11) The D-SS ordered a new horizontal storage cart system for the esophageal dilators that is compliant with the IFU for storage (does not contain foam). The dilators were reprocessed and placed into the new cart on November 8, 2024 and hands-on staff education was completed based on the IFU prior to staff use and handling of the cart. Education was logged and will be audited. The D-SS disposed of the former (foam lined) storage device. 12) A BioMed staff member completed cleaning of the filters on the two (2) Medivators in Surgical Services on October 24, 2024 as directed by the IT Services Manager (IT-SM). 13) With oversight for the Medivators, BioMed modified their worklist to note the filters are to be changed monthly based on the equipment IFU. 14) BioMed will appropriately complete the logs associated with each Medivator, specifically noting the monthly filter cleaning as required. **A940 Performance Monitoring** 1) The D-R or designee will monitor the enzymatic soak/cleaning log in the echocardiogram room monthly for three (3) months to monitor for 100% compliance with recording on the log. The D-R will report findings monthly to the CIO, IP-RN, and the QAPI Committee. The QAPI Committee will determine if 100% compliance has been achieved; or if audits shall continue monthly until compliance has been achieved.	

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A 940	Continued From page 10 processing technician C revealed: *Seven containers of contaminated instruments including scissors, drills, irrigation cannulas, pickups, and screwdrivers were on a long table with wheels. *Some instruments had not been placed in containers and were lying flat on the table. *The table was pushed from the OR into the OR corridor and rolled to decontamination. *The instruments had been separated and treated with pre-klenz and were not placed in sealed containers. *The irrigation cannulas contained dried blood and were not soaked in a container. *A large drape had been placed over the instruments in the containers. *A large red drape containing a biohazard label was then draped over the entire table containing the instruments. *She confirmed: -The containers for transporting the used instruments did not have lids. -Every single instrument could have punctured the drape if they fell off the table. -Not all contaminated instruments had been sprayed with pre-klenz. -"It's not the expectation of OR staff to spray the instruments even though surgical leadership says it is." Interview on 10/21/24 at 3:50 p.m. with sterile processing department coordinator B confirmed: *Contaminated surgical instruments should have been pretreated with pre-klenz or placed in water in the operating room (OR). *Contaminated surgical instruments had not been transported in sealed, leak proof, puncture resistant containers. *The surgical instruments could have punctured	A 940	A940 (continued from Page 10) 2) The D-R will audit receipt of attestations from cardiac sonographers indicating their review of information and education about appropriate mixing of Prolystica and water for cleaning the TEE probe. The audits will occur weekly until 100% of cardiac sonography staff have attested. Audit results will be reported monthly by the D-R to the CIO and the QAPI Committee. The QAPI Committee will determine if compliance has been met by 100% completion of the education attestation; or if audits will continue monthly until compliance has been met. 3) The D-SS or designee will monitor the enzymatic soak/cleaning log in the decontamination room in surgical services monthly for three (3) months to monitor for 100% compliance with recording on the log. The D-SS will report findings monthly to the IP-RN and the QAPI Committee. The QAPI Committee will determine if 100% compliance has been achieved; or if audits shall continue monthly until compliance has been achieved. 4) The D-SS or designee will conduct a daily (Monday-Friday, excluding holidays) audit for the presence of the water line tub markings in the decontamination room where the Prolystica Enzymatic Cleaner is mixed and that the log is being completed. 100% presence of the water line and log completion is expected. This audit will occur for three (3) months or until compliance is achieved. Audit findings will be reported monthly by D-SS to the IP-RN and the QAPI Committee. The QAPI Committee will determine if 100% compliance has been achieved; or if the audits will continue weekly until compliance is achieved.	

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A 940	Continued From page 11 through the red drape covering the surgical instruments. *The sterile processing department follows the Association for the Advancement of Medical Instrumentation (AAMI) to guide their practice and write policies. Interview on 10/22/24 at 9:34 a.m. with director of surgical services A confirmed: *Contaminated surgical instruments should have been transported in a sealed, leak proof, puncture resistant container. *The expectation was all contaminated surgical instruments should have been sprayed with pre-klenz in the OR prior to transport to decontamination room. Review of the provider's November 2023 Waste Disposal, Including Infectious/Biohazardous policy revealed: *"All infectious waste must be placed in a closeable, leak proof containers or bags marked with the biohazard warning symbol or red in color. *All containers utilized for blood and/or other potentially infectious/hazardous material collections must be transported in containers that prevent leaking." Review of the provider's 5/19/24 Lippincott Procedures-Cleaning and Transporting Instruments, OR revealed: *"At the completion of the surgical procedure, perioperative staff must properly prepare instruments for transport to protect the instruments from damage and prevent injuries. *Separate sharp instruments from other instruments and place them in a puncture-resistant container for transport to limit the risk of injury.	A 940	A940 (continued from Page 11) 5) The D-SS or designee will audit the instrumentation drop off log daily (Monday-Friday, excluding holidays) for one month and weekly for two (2) months to ensure completion and compliance with expected handling of instrumentation following surgical procedures. Audit findings will be reported by the D-SS to the IP-RN and QAPI Committee monthly and the QAPI Committee will determine if 100% compliance has been achieved; or if the audit will continue at weekly intervals until compliance has been achieved. 6) The D-SS or designee will audit staff education attestations for completion for appropriate mixing of Prolystica to water in the decontamination room; review of the procedure for handling of surgical instruments; appropriate use of the red bins for instrument transportation; use and handling of the horizontal storage cart (dilators); and return demonstration on instrument handling. These audits will occur weekly until 100% of applicable staff have completed all necessary attestations. Audit findings will be reported by the D-SS to the QAPI Committee monthly and the QAPI Committee will determine if 100% compliance has been achieved; or if the audits will continue at weekly intervals until compliance is achieved. 7)The IT-SM will audit the Medivator logs monthly for three (3) months to validate 100% compliance with monthly Medivator filter cleaning. The IT-SM will report audit findings to the CIO, IP-RN, and the QAPI Committee monthly. The QAPI Committee will determine when 100% compliance has been achieved; or if audits shall continue monthly until compliance is achieved	

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A 940	Continued From page 13 sides, labeled as biohazardous, and sealed. *Rationale: Materials contaminated with blood or other bodily fluids can serve as a source of infection to personnel unless the materials are completed contained. Containment minimizes the possibility of airborne or contact spread of microorganisms." 3. Observation and interview on 10/22/24 at 9:10 a.m. in the scope storage room with RN E revealed: *A carrying case containing 16 esophageal dilators was hung on the wall. -The carrying case had been lined with foam to protect dilators. *The dilators were cleaned using high level disinfectant (HLD) according to the manufacturer's IFU. *After HLD, the dilators were placed back into the carrying case. *She stated, "This has always been the practice." *Confirmed the carrying case lined with foam had not been cleaned. Review of providers August 2024 Cleaning, Disinfecting, and Sterilization of Instrumentation and Medical Equipment policy revealed, "Department directors and managers will have oversight and responsibility that IFU's for patient care items, instruments and medical equipment used in their department are followed." Review of the manufacturer's February 2023 SafeGuide Over the Guidewire Esophageal Dilatation System IFU revealed: *Storage -"The SafeGuide Dilators should be out of direct light, and at room temperature. -SafeGuide Dilators may be stored flat or hung	A 940		

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A 940	Continued From page 14 vertically in any of the esophageal dilator storage solutions from Diversatek Healthcare including the wall-mount storage cabinet, horizontal storage cart, or vertical storage cart." 4. Interview on 10/23/24 at 9:10 a.m. with registered nurse (RN)/ infection prevention staff F and G revealed: *Contaminated surgical instruments should have been transported in a closed, puncture resistant, leak proof container labeled as biohazardous. *Contaminated instruments were cleaned at point of use with pre-klenz. *Storing the esophageal dilators in a lined foam case after HLD would not have been an acceptable practice. *The foam lining within the carrying case would not have been cleanable. *Staff should have been following the manufacturer's IFU regarding the storage of esophageal dilators. *RN, Infection Prevention G stated, "This will get fixed immediately." 5. Observation and interview on 10/22/24 at 9:13 a.m. with RN E of the endoscope reprocessing medivator's filter change logs revealed: *Medivator A/B reusable mesh disinfectant filter should have been cleaned monthly. -Documentation of a filter clean had been completed every three months instead of monthly. *Medivator C/D reusable mesh disinfectant filter should have been cleaned monthly. -Documentation of a filter clean had been completed every three months instead of monthly. *She was unaware if the medivator's manufacturer's IFU had changed.	A 940		

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A 940	Continued From page 15 *She would need to speak with biomed to clarify the correct process. Interview on 10/23/24 at 3:00 p.m. with director of surgical services A and sterile processing department coordinator B confirmed: *The disinfectant filters for both medivators should have been cleaned monthly per the manufacturer's IFU. *They would have expected documentation on the filter change logs to reflect cleaning had been performed. *Biomed would begin cleaning the reusable mesh disinfectant filters monthly. Review of the manufacturer's 2015 Medivators DSDEDGE Endoscope Reprocessing System IFU pg. 64 revealed, "The filter is located below the overflow valve and is part of the drain manifold assembly. This should be checked and cleaned on a monthly basis."	A 940		

South Dakota Department of Health

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	10572 S	A. BUILDING: _____ B. WING _____	10/23/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 10/21/24 through 10/23/24. Prairie Lakes Hospital was found not in compliance with the following requirement: S149.	S 000		
S 149	44:75:02:10.01(1-5) Antibiotic Stewardship Program Each facility shall, based on recommendations from the facility's medical and pharmacy leadership, appoint an antibiotic stewardship director who is qualified through education, training, experience, or certification in infectious disease or antibiotic stewardship, to be responsible for the antibiotic stewardship program including: (1) Developing and implementing policies and procedures for facility-wide antibiotic stewardship to monitor and improve the facility's use of antibiotics that reflect the scope and complexity of services furnished by the facility; (2) Documenting antibiotic stewardship activities to include sustained improvements in proper antibiotic use; (3) Communicating and collaborating with medical, nursing, and pharmacy personnel and with the quality assessment and performance program required by § 44:75:04:14 and the infection prevention and control program required by § 44:75:02:10 on antibiotic stewardship issues; (4) Ensuring competency-based training and education is provided to the facility's healthcare personnel on the practical application of antibiotic stewardship guidelines, policies, and procedures; and	S 149	**S149 Corrective Action** 1) The Director of Pharmacy (D-P), Director of Quality and Risk Management (D-QRM), Senior Director of Inpatient Services (D-IS), Infection Prevention Coordinator (IP-C), Infection Prevention RN (IP-RN), Director of Lab (D-L) met on October 24, 2024 to discuss a plan for implementation of Antimicrobial Stewardship (AMS) education for all staff; to include physicians, nurse practitioners (NPs), and physician assistants (Pas) as well as a regular meetings schedule for the AMS team. 2) The D-P or designee will schedule the AMS Team, with applicable attendees based on the hospital's Antimicrobial Stewardship Program policy, to meet monthly for the next three (3) months then at least quarterly thereafter starting in November 2024 and that meeting minutes are written and maintained to reflect the details of meeting discussion and decision-making. 3) The D-P will develop a QAPI project specific to AMS and provide a monthly report out to the QAPI Committee for the next three (3) months then quarterly thereafter. QAPI minutes will summarize the update provided by the D-P. 4) The D-P or designee will develop and incorporate AMS education content for the on-line, annual mandatory training for all the organization's staff, physicians, NPs, and PAs; this is also used for new employee onboarding.	12/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Allen John Allen — TITLE: CEO — (X6) DATE: 11/08/2024 11/14/2024

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S 149	Continued From page 1 (5) Auditing adherence to the facility's antibiotic stewardship policies. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, antimicrobial stewardship meeting minutes, and policy review, the provider failed to: *Implement an effective and functioning antibiotic stewardship program to ensure the proper use of antimicrobial resources and for the improvement of patient safety. *Provide competency based training and education to personnel on the application of antibiotic stewardship guidelines policies and procedures. Findings include: 1. Interview on 10/23/24 at 11:35 a.m. with director of pharmacy L and pharmacist M regarding the provider's antimicrobial stewardship program revealed: *Training and documentation for providers, staff, and appropriate personnel providing contracted services had not occurred. *The antimicrobial team met on 8/20/24 and again on 9/22/24. *Prior to the above listed dates, the last antimicrobial stewardship meeting had occurred sometimes in 2023. -She was not able to provide specific dates in 2023. -No additional meeting minutes were provided for review. Review of the provider's antibiotic stewardship committee minutes revealed: *The 8/20/24 meeting was conducted to discuss: -The current antibiotic stewardship policy and	S 149	S149 (continued from Page 1) 5) The D-P or designee will provide AMS education content in the monthly (no end date) Quality Newsletter starting with the November 2024 edition. This newsletter is sent via email to all staff, physicians, NPs, and PAs, and is included in the meeting materials distributed to the Board of Directors for their regularly scheduled meetings. 6) The D-P or designee will collaborate with the Director of Marketing (D-M) to incorporate AMS education into the organization's social media platforms and other venues (such as a booth or marketing media at health events). 7) The D-P provided AMS education at the November 7, 2024, Quarterly Medical Staff meeting and will send (via email with a "read receipt" function) a summary of AMS information covered to all physicians, NPs, and PAs, with active staff privileges (excluding telehealth providers) on November 14, 2024. 8) The D-P or designee will develop and distribute AMS education content for inclusion in onboarding materials provided to contracted staff or agency staff (locum physicians, travel staff). 9) The D-P revised the organization's Antimicrobial Stewardship Program policy to align with, and incorporate, core elements outlined in the *Centers for Disease Control (CDC): Core Elements of Hospital Antibiotic Stewardship Programs (2019).* **S149 Performance Monitoring** (continued next page)	

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S 149	Continued From page 2 compliance with South Dakota Administrative Laws. -Which team member would have contacted physicians on the antibiotic team. -The next scheduled meeting was to review the current policies and procedures, ongoing process, and further development of the antimicrobial stewardship program. *The 9/5/24 meeting was conducted to discuss: -Establishing the antimicrobial stewardship program as a formal QAPI project for performance improvement. -The Center for Medicare and Medicaid requirements/regulations surrounding antimicrobial stewardship. -A review of the provider's infection control Association for Professionals in Infection Control and Epidemiology library for information on different antimicrobial policies and procedures to add or remove items from the current policy. Review of the provider's Antimicrobial Stewardship Team policy dated January 2024 revealed the antimicrobial stewardship team should have: *Met quarterly, to include but not limited to pharmacy. *Worked on all areas in the facility to ensure proper reporting of antibiotic use. *Provided staff education on appropriate antibiotic usage. *Maintained team competencies by regularly seeking out related educational opportunities.	S 149	S149 (continued from Page 2) **S149 Performance Monitoring** 1) The D-QRM will audit the AMS Committee agenda, content, and meeting minutes monthly for three (3) months and quarterly for three (3) quarters to ensure 100% compliance with elements of the organization's Antimicrobial Stewardship Program policy. Audit results will be reported by the D-QRM to the Chief Nursing Officer (CNO), QAPI Committee and the Medical Executive Committee (MEC). The MEC will determine if compliance has been met or if audits need to continue quarterly until compliance has been met. 2) The D-P or designee will audit the delivery of the email AMS education by monitoring the "read receipts" from the email sent out. This audit will continue weekly until 100% of those receiving the email education have responded with a "read receipt" or a signed attestation form indicating they received the email education. Audit results will be reported monthly by the D-P to the D-QRM, CNO, QAPI Committee, and the MEC. The MEC will determine if compliance has been met or if the audit needs to continue weekly until compliance has been met. 2) The D-P will audit delivery of onboarding materials to contract staff (physician and non-physician) and new employee hires monthly for six (6) months to ensure delivery of AMS education to 100% of contract staff and new employees. Audit findings will be reported by the D-P to the D-QRM, CNO and the QAPI Committee. The QAPI Committee will determine if compliance has been met as evidenced by 100% of contract providers and new staff received AMS education; or if audits need to continue monthly until compliance has been met.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 482.15, Emergency Preparedness, requirements for Hospitals and Specialized Hospitals, was conducted from 10/21/24 through 10/22/24. Prairie Lakes Hospital was found in compliance.	E 000		

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

John Allen | CEO | 11/08/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted 10/21/24 and 10/22/24 for compliance with 42 CFR 482.41(b)(1), requirements for Hospitals. Prairie Lakes Hospital (building 1) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K321 and K500 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress paths free of hazards for three of seventeen exits (adjacent to sterilization, stairwell at door 0023, and stairwell at door 0012). Findings include: 1. Observation on 10/22/24 at 9:15 a.m. revealed the path of egress adjacent to the sterilization area was very cluttered on each side of the corridor. The area was over 100 square feet in area and had combustible items (large amounts of cardboard boxes with supplies as well as carts) making the area hazardous. Paths of egress	K 211	**K211 Corrective Action** 1) The Director of Facilities Management (D-FM) delegated Facilities Management (FM) staff to clear the path of egress adjacent to the sterilization areas on November 1, 2024. 2) The D-FM delegated FM staff to clear items being stored at the bottom of the stairwell through door 0023 on November 1, 2024. 3) The D-FM delegated FM staff to clear items stored at the bottom of the stairwell through door 0012 on November 1, 2024. **K211 Performance Monitoring** 1) The IT Services Manager (IT-SM) who oversees the BioMed Department, will audit the staff egress adjacent to the sterilization area and the bottom the stairwells through doors 0023 and 0012 weekly for three (3) months to ensure there is 100% compliance with no items being stored in these locations. Audit results will be reported monthly to the Chief Information Officer (CIO) and the QAPI Committee who will determine if compliance has been met as evidenced by no items beings stored in these locations; or if audits will continue at weekly intervals until compliance has been met.	12/02/2024

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John Allen John Allen | CEO | 11/08/2024 11/14/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 must not be through hazardous locations. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and if so designated as an area of refuge. LSC 7.1.3.2.3 2. Observation on 10/22/24 at 9:20 a.m. revealed storage at the bottom of the stairwell accessed through door 0023. The area was directly under the stairs leading to the exit and had combustible items (4 laundry carts and five large boxes) making the stairwell a hazardous location. Paths of egress must not be through hazardous locations. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and if so designated as an area of refuge. LSC 7.1.3.2.3 3. Observation on 10/22/24 at 9:27 a.m. revealed storage at the bottom of the stairwell accessed through door 0012. The area was directly under the stairs leading to the exit and had combustible items (carts from the sterilization area, boxes, and a bed) making the stairwell a hazardous location. Paths of egress must not be through hazardous locations. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and if so designated as an area of refuge. LSC 7.1.3.2.3 Interview with the facilities management director at the time of the observation confirmed that condition. He was aware of the prohibition of storage in a protected exit. The deficiency had the potential to affect 100% of the smoke compartment's occupants.	K 211		
K 321	Hazardous Areas - Enclosure	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas (trash storage 2451, and soiled laundry) as required. Findings include: 1. Observation on 10/21/24 at 4:25 p.m. revealed the storage room at 2451 was in fact a trash	K 321	**K321 Corrective Action** 1) We do not have a door labeled as 2451 in our facility. With knowledge from the survey walkthrough the D-FM delegated FM staff to install a door closer on door 3051 on October 23, 2024 as this was the door the surveyor had identified needing a closer during the survey. 2) The D-M delegated FM staff to install a rated door with a closer at door 0029A which is between soiled laundry and laundry on October 31, 2024. **K 321 Performance Monitoring** 1) The D-FM or designee will check doors 3051 and 0029A weekly for three (3) months to ensure the automatic door closure is 100% functional. Audit findings will be reported to the CIO and the QAPI Committee who will determine if compliance has been met or if audits will continue at weekly intervals until compliance is achieved.	12/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

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K 321	Continued From page 3 storage room containing more than 64 gallons of trash, and had no automatic door closer. 2. Observation on 10/22/24 at 7:25 a.m. revealed the door separating soiled laundry from laundry was not a rated door, nor did it have an automatic door closer. The volume of stored soiled linens was greater than 64 gallons. The integrity of this door was also very low. Interview with the facilities management director at the times of the observations confirmed those findings. The deficiency affected three of numerous requirements for hazardous rooms.	K 321		
K 500	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain laundry airflow in a clean to dirty relationship and failed to identify a potentially hazardous breathing environment as required. Findings include: 1. Observation and testing on 10/22/24 at 7:45	K 500	**K500 Corrective Action** 1) The D-FM directed the FM staff to adjust the air flow in dirty laundry area so the positive air pressure does not go to the corridor on October 31, 2024. 2) The D-FM coordinated installation of signage indicating "Caution: Carbon Dioxide" on the door where the H-cylinders containing carbon dioxide are stored on October 29, 2024. **K500 Performance Monitoring** 1) The D-FM or designee will perform a tissue test to confirm air flow is not going from the soiled laundry to the corridor or to the laundry folding area. This testing will be done weekly for three (3) months to ensure appropriate air flow. Tissue testing indicating unacceptable airflow will be addressed immediately by FM. (continued next page)	12/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **01 - BUILDING 01** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

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K 500	Continued From page 4 a.m. of the pressure relationships between clean and dirty spaces in the laundry room revealed the following: a. Using a tissue test, the dirty side of the laundry was determined to have a positive air pressure relationship with the corridor. b. The folding room was immediately across the hall from the dirty laundry, and the doors were held open. This room had a negative pressure relationship to the corridor. The result of these tests show dirty air would flow into the clean area. 2. Observation on 10/21/24 at 1:30 p.m. revealed a room marked as storage on the first floor contained sixteen H-cylinders containing carbon dioxide. The Carbon Dioxide Manufacturers Association lists a "normal" storage amount as one cylinder. There is no listed prohibition or added requirements for ventilation until 3000 cubic feet of storage is reached, however displacement of air may become hazardous. Signage for compressed gas storage is required. Interview with the facilities management director at the time of the observations confirmed those findings. The deficiency affected two of several requirements for ventilation.	K 500	K500 (continued from Page 4) Audit findings will be reported monthly by the D-FM to the CIO and the QAPI Committee who will determine if compliance has been met as evidenced by 100% appropriate air flow or if audits will continue at weekly intervals until compliance is achieved.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	430005	A. BUILDING **02 - BUILDING 02** B. WING _____	**10/22/2024**

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PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

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K 000	INITIAL COMMENTS A recertification survey was conducted 10/21/24 and 10/22/24 for compliance with 42 CFR 482.41(b)(1), requirements for Hospitals. Prairie Lakes Hospital (building 1) was found in compliance.	K 000		

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

John Allen | CEO | 11/08/2024

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	430005	A. BUILDING **03 - BUILDING 03** B. WING _____	**10/22/2024**

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PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

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K 000	INITIAL COMMENTS A recertification survey was conducted 10/21/24 and 10/22/24 for compliance with 42 CFR 482.41(b)(1), requirements for Hospitals. Prairie Lakes Hospital (building 1) was found in compliance.	K 000		

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

John Allen

TITLE

CEO

(X6) DATE

11/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	430005	A. BUILDING **05 - MEDICAL OFFICE BUILDING** B. WING _____	**10/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210** **WATERTOWN, SD 57201**

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K 000	INITIAL COMMENTS A recertification survey was conducted 10/21/24 and 10/22/24 for compliance with 42 CFR 482.41(b)(1), requirements for Hospitals. Prairie Lakes Hospital (building 1) was found in compliance.	K 000		

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	430005	A. BUILDING **06 - MALLARD POINT** B. WING _____	**10/22/2024**

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PRAIRIE LAKES HOSPITAL	**401 9TH AVENUE NW POST OFFICE BOX 1210 WATERTOWN, SD 57201**

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K 000	INITIAL COMMENTS AA recertification survey was conducted 10/21/24 and 10/22/24 for compliance with 42 CFR 482.41(b)(1), requirements for Hospitals. Prairie Lakes Hospital (building 1) was found in compliance.	K 000		

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