STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433300	A. BUILDING _____ B. WING _____	06/18/2025

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LIFESCAPE	2501 W 26TH ST SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals was conducted from 6/16/25 through 6/18/25. Lifescape was found not compliance with the hospital's Conditions of Participation with the following requirements: A396, A398, and A726.	A 000	Lippincott Care Plan Preparation Procedure was updated to reflect LifeScape Care Plan requirements. The Director of Nursing, Nurse manager, or designee will train all nursing staff on care plan non-compliance 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, 30. Training on care plans will include "Lippincott Care Plan Preparation" Procedure on all future patients To monitor performance, and identify future noncompliance, audits will be conducted by the Care Coordinator, Nursing Manager or designee on a sample of 50% of charts weekly for 90 days, and then monthly for 6 months. Results will be tracked and reviewed by the DON and reported to QAPI quarterly.	Completed By August 2nd, 2025
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure patient's care plans had been implemented upon admission and documented on 1 time per shift for 29 of 30 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, 26, 27, 28, 29, and 30) medical records. Findings include: 1. Review of the above listed patient's medical records revealed: *Patient 1 had: -Been admitted on 12/30/24 with a diagnosis of respiratory failure (when the lungs can't properly exchange gases) of a preterm infant. -A care plan that had been initiated and documented on 12/30/24. -Care plans that had not been updated or documented from 12/31/24 through 1/6/25 and 1/16/25 through 1/31/25. *Patient 2 had:	A 396		

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

Steve Wahl — CEO — 7/15/25

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 396	Continued From page 1 -Been admitted on 6/6/25 with a diagnosis of myelin oligodendrocyte glycoprotein antibody-associated disease (inflammatory disease that affects the central nervous system) and autism disorder (neurological disorder that affects how people communicate, learn, and behave). -A care plan that had been initiated and documented on 6/7/25. -Care plans that had not been updated or documented on 6/9/25, 6/10/25, and 6/11/25. -Discharged on 6/16/25. *Patient 3 had: -Been admitted on 11/5/24 with a diagnosis of anoxic brain injury (when the brain doesn't receive enough oxygen). -A care plan that had been initiated and documented on 11/7/24. *Patient 4 had: -Been admitted on 4/10/24 with a diagnosis of prematurity and bronchopulmonary dysplasia (lung condition that affects premature babies with breathing problems and oxygen needs). -A care plan that had been initiated and documented on 4/11/24. -Care plans that had not been updated or documented from 5/26/25 through 6/8/25. *Patient 5 had been admitted on 2/27/23 with a diagnosis of prematurity and Pallister-Killian syndrome (genetic disorder caused by an extra chromosome). -The patient's only care plans were initiated and documented on 11/13/24 and 6/16/25. *Patient 6 had been admitted on 2/10/21 with a diagnosis of riboflavin transporter deficiency (progressive neurodegenerative disease). -The patient's initial care plan was initiated and documented on 2/12/24. *Patient 7 had:	A 396		

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A 396	Continued From page 2 -Been admitted on 2/3/22 with a diagnosis of chronic respiratory failure and tracheomalacia (cartilage in the windpipe is weak or floppy). -A care plan that had been initiated and documented on 2/13/24. -Care plans that had not been updated or documented from 5/26/25 through 6/5/25. *Patient 8 had: -Been admitted on 4/17/24 with a diagnosis of a chromosomal abnormality. -A care plan that had been initiated and documented on 4/1/25. -Care plans that had not been updated or documented from 5/26/25 through 6/5/25. *Patient 9 had been admitted on 6/5/25 with a diagnosis of chronic respiratory failure (when the lungs can't adequately oxygenate the blood or remove carbon dioxide) and prematurity. -The patient's initial care plan was initiated and documented on 6/16/25. *Patient 10 had: -Been admitted on 5/21/24 with a diagnosis of severe hypoxic-ischemic encephalopathy (condition resulting from insufficient blood and oxygen flow to the brain) and fetal alcohol syndrome (condition that results from alcohol exposure during the mother's pregnancy). -A care plan that had been initiated and documented on 5/24/24. -Care plans that had not been updated or documented from 5/30/25 through 6/4/25. *Patient 11 had: -Been admitted on 8/15/23 with a diagnosis of severe hypoxic-ischemic encephalopathy. -A care plan that had been initiated and documented on 2/13/24. -Care plans that had not been updated or documented from 5/26/25 through 6/2/25. *Patient 12 had:	A 396		

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A 396	Continued From page 3 -Been admitted on 1/19/21 with a diagnosis of respiratory failure. -A care plan that had been initiated and documented on 2/12/24. -Care plans that had not been updated or documented from 2/12/24 through 4/19/24 and from 5/26/25 through 6/13/25. *Patient 13 had: -She had been admitted on 8/30/23 with a diagnosis of glutaric acidemia, type 1 (metabolic disorder causing the body to have trouble breaking down amino acids). -A care plan had been initiated and documented on 2/13/24. -Care plans had not been updated and documented on 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25 and 3/23/25 for the last 3 weeks of the patient's admission. *Patient 14 had: -He had been admitted on 3/30/23 with a diagnosis of short bowel syndrome (shortened small intestine making difficult to absorb nutrients). -A care plan had been initiated and documented on 3/30/23. -Care plans had not been updated and documented on 5/5/25, 5/16/25, and 5/17/25 for the last 3 weeks of the patient's admission. *Patient 15 had: -He had been admitted on 3/28/25 with a diagnosis of aspiration pneumonia (lung infection caused by inhalation of liquid into the lung). -A care plan had been initiated and documented on 3/28/25. -Care plans had not been updated and documented from 4/5/25-4/10/25 for the last 3 weeks of admission. *Patient 16 had: -She had been admitted on 3/14/25 with a	A 396		

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A 396	Continued From page 4 diagnosis of B-Cell acute lymphoblastic leukemia (type of blood cancer that too many immature B-Cells have been produced by the bone marrow). -A care plan had been initiated and documented on 3/15/25. -No care plans that had been updated and documented from 3/17/25 through her discharge date of 3/21/25. *Patient 17 had: -He had been admitted on 2/14/25 with a diagnosis of Di George Syndrome (genetic disorder caused by a missing piece of chromosome 22). -A care plans had been initiated and documented on 2/18/25. -The patient's only updated and documented care plan was on 2/20/25. *Patient 18 had: -He had been admitted on 1/7/25 with a diagnosis of prematurity (baby born before 37 weeks of pregnancy). -A care plan had been initiated and documented on 1/8/25. -Care plans had not been updated and documented from 1/9/25 through 1/30/25. -He had been discharged on 2/18/25. *Patient 19: -He had been admitted on 12/17/24 with a diagnosis of a subdural hematoma (condition where blood collects between the brain and its outer covering). -A care plan had been initiated and documented on 12/18/25. -Care plans had not been updated and documented on 12/22/24, 12/23/24, 12/25/24, and 12/26/24. *Patient 20 had: -Been admitted on 11/12/24 with a diagnosis of	A 396		

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A 396	Continued From page 5 status post motor vehicle accident (MVA) with traumatic brain injury (TBI) (brain injury from a violent blow or jolt to the head) and was discharged on 12/13/24. -A care plan had been initiated and documented on 11/13/24. -Care plans had not been updated or documented on 11/20/24, 11/23/24, 11/27/24 through 12/1/24, and 12/10/24. *Patient 21 had: -Been admitted on 12/2/24 with a diagnosis of status post MVA and spinal cord injury (damage to the spinal cord) and was discharged on 12/13/24. -A care plan had been initiated and documented on 12/3/24. -Care plans had not been updated or documented on 12/8/24 and 12/10/24. *Patient 22 had: -Been admitted on 11/18/24 for respiratory failure and was discharged on 11/27/24. -A care plan had been initiated and documented on 11/18/24. -Care plans had not been updated or documented on 11/20/24 and 11/23/24. *Patient 23 had: -Been admitted on 11/9/24 with a diagnosis of status post meningitis (inflammation of brain and spinal cord), epilepsy (seizures), and stroke (blood flow to the brain is interrupted) and was discharged on 11/15/24. -A care plan had been initiated and documented on 11/9/24. -Care plans had not been updated or documented on 11/11/24. *Patient 24 had: -Been admitted on 10/29/24 with a diagnosis of status post MVA and was discharged on 11/14/24. -A care plan had been initiated and documented	A 396		

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A 396	Continued From page 6 on 10/30/24. -Care plans had not been updated or documented on 10/31/24 through 11/3/24,11/5/24 through 11/10/24, and 11/12/14 through 11/14/24. *Patient 26 had: -Been admitted on 9/18/24 with a diagnosis of status post fall from a ladder and TBI and was discharged on 10/3/24. -A care plan had not been initiated or documented on until 9/24/24. -Care plans had not been updated or documented on 10/1/24 and 10/2/24. *Patient 27 had: -Been admitted on 9/23/24 related to a brain tumor and required a resection of her ventricular shunt (device that drains fluid from the brain) and was discharged on 10/3/24. -Her initial care plan had been documented on 9/23/24. -Care plans had not been documented on 10/1/24 through 10/3/24. *Patient 28: -He had been admitted on 8/30/24 related to a brain mass and difficulty with speech and discharged on 9/27/24. -A care plan had not been initiated or documented on until 9/7/24. -Care plans had not been updated or documented on 9/9/24, 9/11/24, 9/12/24/ 9/14/24, 9/16/24, 9/18/24, and 9/20/24 through 9/23/24. *Patient 29 had: -Been admitted on 9/13/24 with a diagnosis of a respiratory illness and generalized weakness and was discharged on 9/23/24. -A care plan had not been initiated or documented on until 9/15/24. -Care plans had not been updated or documented on 9/16/24 through 9/18/24 and 9/20/24 through 9/23/24.	A 396		

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A 396	Continued From page 7 *Patient 30 had: -Been admitted on 7/25/24 with a diagnosis of status post fall from a horse and an L3 burst fracture (spinal injury where the third lumbar vertebra (L3) in the lower back is fractured due to a forceful compression), and leg weakness and was discharged on 8/6/24. -A care plan had not been initiated or documented on until 7/27/24. -Care plans had not been updated or documented on 7/28/24 and 7/29/24. Interview on 6/17/25 at 3:30 p.m. with nurse manager E regarding nursing care plan documentation revealed: *Care plans should have been initiated by the nursing staff upon a patient's admission to the hospital. *Care plans should have been updated and documented on regarding the patient's progress one time per shift daily by the nursing staff until the patient discharged. *She agreed with the above findings. Interview on 6/18/25 at 8:00 a.m. with director of nursing A regarding nursing care plan documentation revealed: *Care plans should have been initiated by the nursing staff within 24 hours of a patient's admission. *Care plans should have been documented on once per shift by the nursing staff until the patients were discharged. Review of the provider's June 2025 Admission Assessment policy revealed: *"An initial care plan will be implemented upon [a patient's] admission (within 24 hours) to the Specialty Hospital.	A 396		

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A 396	Continued From page 8 *The [patient's] care plan should be documented on a minimum of 1 x [time] per shift." Review of the provider's 6/2025 Care Plan Preparation Procedure and Checklist revealed, "Care plans should be completed within 24 hours of [a patient's] admission, and charted on a minimum of 1 x per shift."	A 396		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on observation, interview, policy review, employee files review, and manufacturer's instructions for use (IFU) review, the provider failed to ensure: *One of one Lifepak 20e (defibrillator) had been checked daily per the manufacturer's IFU. *Staff on duty had been properly trained to operate and perform the required daily checks on the Lifepak 20e. Findings include: 1. Observation and interview on 6/16/25 at 11:00 a.m. with registered nurse (RN) B and RN C in the acute inpatient area by the nurse's station revealed: *A Lifepak 20e defibrillator was located on top of	A 398	There is no regulation that requires a defibrillator in the Specialty Hospital. LifeScape leadership had a discussion with members of their medical staff in regards to defibrillator on the Crash Cart which also contains an AED. A pediatrician consulted with cardiology and PICU director and the recommendation was to approve the removal of the defibrillator from the Specialty Hospital. The medical executive committee approved the motion to remove the defibrillator. "Crash Cart and Emergency Medications and Supplies for Specialty Hospital and ICF" Policy was updated to reflect the removal of the defibrillator. All nursing Staff will be trained on the removal of the defibrillator and updated policy "Crash Cart and Emergency Medications and Supplies for Specialty Hospital and ICF".	Completed By August 2, 2025

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A 398	Continued From page 9 the crash cart. *RN B stated the defibrillator printed out a daily test that was to be attached to the daily checklist and marked off as completed. -That had been their only process for the daily checks of the defibrillator. *RN C stated, "We do not touch the machine. We would not use the Lifepak, we only use the AED" [automatic external defibrillator]. *RN B and RN C stated they had not performed other checks on the defibrillator as they do not operate the machine unless they have a physician's order to. *RN B stated some physicians used the defibrillator to monitor a patient's heart rhythm if requested. *RN B stated she was unsure why the provider had both a defibrillator and an AED. *RN B confirmed staff had not performed the steps according to the manufacturer's IFU for checking the Lifepak 20e defibrillator. Interview on 6/16/25 at 11:25 a.m. with director of nursing (DON) A regarding the Lifepak 20e defibrillator revealed: *She had thought the provider needed to have both a defibrillator and an AED available for use. *She stated that if the physician had been in the building, the staff would have used the Lifepak defibrillator per the direction of the physician. *She had been unaware their checklist had not followed the manufacturer's IFU. Interview on 6/17/25 at 9:15 a.m. with DON A and vice president (VP), medical and therapy services F revealed: *DON A confirmed the Lifepak 20e defibrillator was brought into the hospital in 2019. *An educational in-service had been provided to	A 398		

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A 398	Continued From page 10 the staff from Medtronic (medical device company), but no additional training had been provided on the use of the defibrillator since. *DON A and VP, medical and therapy services F agreed staff should have had the proper training to have operated and maintained the defibrillator according to the manufacturer's IFU. *Review of the provider's Daily Crash Cart Checklist revealed a section for staff to document the defibrillator check but it had not included the additional instructions as directed by the manufacturer's IFU. Review of the provider's 10/27/2022 Emergency-Code Blue policy revealed: "All staff will be instructed on the proper method for obtaining emergency medical services during the first day of employment and annually thereafter." Review of the provider's 4/16/2024 Crash Cart and Emergency Medication/Supplies policy revealed: *"Crash carts are checked a minimum of monthly to ensure the following: -Fisher Coon Monthly Crash Cart Checklist: --Defibrillator with electrodes." Review of the provider's undated Code Blue Medical Response annual education pg. 13 revealed: *"First Person On The Scene: -Follow your training, call for medical response, assess the situation, and begin CPR if needed. -Help ensure the area is safe, get the AED, call 911 if needed, help with compressions if trained." Review of the manufacturer's 2019 IFU for the Lifepak 20e Defibrillator/Monitor Operator's	A 398		

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A 398	Continued From page 11 Checklist revealed: *"1. Check printed result of 3 A.M. daily auto test. *2. Inspect physical condition for: -Foreign substances. -Damages or cracks. *3. Inspect power source *4. Check therapy and ECG electrodes for: -Use by date. -Spare electrodes [are] available. *5. Examine accessory cables for: -Cracking, damage, broken or bent parts or pins, and paddle surfaces for pitting. *6. Disconnect the defibrillator from AC power, wait 2 seconds, press ON and check for: -Momentary SELF-TEST messages, illumination of LEDs, and speaker beep. -Services LED is lit. *7. Check ECG printer for: -Adequate paper supply. -Ability to print. *8. Confirm [the] therapy cable [is] connected to defibrillator to perform [the] cable check: -If QUIK-COMBO therapy cable is connected: --Confirm [the] test plug [is] connected to [the] therapy cable. --Press ANALYZE button. --After ANALYZING NOW message, look for REMOVE TEST PLUG message. *9. Reconnect to AC power and then power off the device." Review of the employee files for DON A, RN C, RN/care coordinator G, RN H, and RN I revealed there was no documentation that they had completed training to safely operate and maintain the defibrillator during their orientation or annual training.	A 398		
A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS	A 726		

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A 726	Continued From page 12 CFR(s): 482.41(d)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, interview, refrigerator/freezer logs review, and policy review, the provider failed to ensure the temperatures of two of two medication refrigerators/freezers had been monitored and documented on daily per hospital policy. Findings include: 1. Observation on 6/16/25 at 10:10 a.m. in exam room 1205 revealed: *A refrigerator containing a single vial of tuberculin purified protein derivative (medication used to diagnose tuberculosis). *There were no documented temperatures for June 2025 for the shifts on: -June 1, a.m./p.m. (morning/evening). -June 3, a.m. -June 4 through June 6, p.m. -June 7 through June 11, a.m./p.m. -June 12, p.m. -June 13, through June 15, a.m./p.m. *In May 2025, there were no documented temperatures the shifts on: -May 1, p.m. -May 3, a.m./p.m. -May 4, a.m./p.m. -May 5, through May 8, p.m. -May 10, a.m./p.m. -May 11, a.m./p.m. -May 12, p.m. -May 14, p.m. -May 17, a.m./p.m. -May 18, a.m./p.m.	A 726	"Storage of Drugs and Biologicals" Policy was updated to include vaccine refrigerator storage and requirements. Vaccine for Children Program (VFC) site visit was completed on 3/18/2025 with no deficiencies. The DON, Nursing Manager, or designee will train the all-nursing staff on the policy "Storage of Drugs and Biologicals". To monitor performance and identify future noncompliance refrigerator audits will be completed by the care coordinator or nurse manager or designee weekly for 3 months and then monthly for 6 months. Results will be tracked and reviewed by the DON and reported to QAPI quarterly.	Completed By August 2, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433300	A. BUILDING _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESCAPE	2501 W 26TH ST SIOUX FALLS, SD 57105

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A 726	Continued From page 13 -May 20, p.m. -May 21, a.m. -May 22, p.m. -May 23, p.m. -May 24, through May 26, a.m./p.m. -May 27, through May 30, p.m. -May 31, a.m./p.m. Interview on 6/16/25 at 10:25 a.m. with registered nurse (RN) B revealed she: *Confirmed staff working in the acute care setting had not been documenting the temperatures of the refrigerator in the exam room. *Stated that refrigerator stored vaccines for patients. *Stated patients in the acute care setting could have received the vaccines that had been stored in the refrigerator. *Confirmed vaccines required daily monitoring and documentation of temperatures. 2. Observation and interview on 6/16/25 at 11:00 a.m. in medication room 1206 with RN C revealed: *A single refrigerator/freezer containing multiple patients' medications. *She stated the temperatures were to be checked and documented daily by the night staff nurse . *The June 2025 temperature log indicated: -June 8 had no documented refrigerator temperature. -June 9 had no documented refrigerator or freezer temperatures. -June 12 had no documented refrigerator or freezer temperatures. *RN C confirmed the above findings and agreed there had been gaps in temperature monitoring for the medication refrigerator and freezer.	A 726		

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A 726	Continued From page 14 Interview on 6/16/25 at 11:25 a.m. with director of nursing A regarding the temperature monitoring and documentation for the refrigerators and freezer medication and/or vaccines were stored revealed: *The staff assigned to monitor and document the temperatures for the vaccine refrigerator had not been documenting on the weekends. *Staff who worked in the inpatient acute setting had not been assigned to monitor and document the temperatures of the vaccine refrigerator located in exam room 1205. *She had not been aware that the temperatures had not been monitored and recorded twice a shift for multiple days both in the a.m. and p.m. for the refrigerator where vaccines were stored. *She agreed the temperatures of the vaccine refrigerator should have been monitored twice a day/seven days per week. *She agreed the temperatures of the refrigerator and freezer containing patient medications in medication room 1206 should have been monitored and documented daily to ensure the safety and efficacy of the medications. Review of the provider's undated Temperature Log for Refrigerator storing vaccines revealed, "1. Record the A.M. and P.M. temperatures each workday. Note the exact time of each temperature reading and the initials of the reader." Review of the provider's 10/2024 Storage of Drugs and Biologicals policy revealed, "The temperature will be checked and recorded once every twenty-four (24) hours."	A 726		

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	433300	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESCAPE	**2501 W 26TH ST SIOUX FALLS, SD 57105**

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K 000	INITIAL COMMENTS A recertification survey for compliance with 42 CFR 382.41(b)(1), requirements for Hospitals was conducted on 6/24/25. Lifescape Children's Hospital - Sioux Falls 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 K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	• The Policy "Oxygen Storage Guidelines" was developed. • The Director of Nursing, Director of Facilities or Designee will train on the policy "Oxygen Storage Guidelines" to all Nursing staff, Patient Care Technicians and maintenance staff. • A Weekly Oxygen Supply Room checklist will be hung in the oxygen supply room (attached). This will be completed by Hospital Environmental Services. • Checking the Oxygen supply room for life safety requirements will be added to the monthly walk through on LifeScape's on-line maintenance platform. • To monitor performance and identify future noncompliance, The Director of Facilities or designee will audit oxygen supply room weekly for 3 months and monthly for 6 months. Results will be tracked and reviewed by Director of Facilities and reported to QAPI quarterly.	Completed By August 2, 2025
K 923	Gas Equipment - Cylinder and Container Storage 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 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.	K 923		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Wall — TITLE: CEO — (X6) DATE: 7/15/25

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
	433300	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESCAPE	**2501 W 26TH ST** **SIOUX FALLS, SD 57105**

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K 923	Continued From page 1 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 protect medical gas storage as required. Oxygen cylinders were not stored with the required precautions. Findings include: 1. Observation on 6/24/25 at 1:35 p.m. in the oxygen storage room with Vice president J revealed two full D-size oxygen cylinders were stored upright outside of the oxygen cylinder storage rack. One C-size oxygen cylinder was found housed within a fabric case and was lying on the floor beside the oxygen cylinder storage rack. Vice president J agreed that the cylinders were stored improperly. The deficiency affected one of one smoke compartments.	K 923		

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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 on 6/24/2025. Lifescape was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 7/10/2025

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