STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKINGS AMBULATORY SURGERY CENTER, LLP	3405 6TH ST , BROOKINGS, South Dakota, 57006

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Q0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 416, Subpart C, requirements for Ambulatory Surgery Centers was conducted from 7/7/25 through 7/8/25. Brookings Ambulatory Surgery Center, LLP was found not in compliance with the following requirements: Q0109 and Q0241.	Q0000		
Q0109	EMERGENCY EQUIPMENT CFR(s): 416.44(d) (d) Standard: Emergency equipment. The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. 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 one of one Lifepak 20 (defibrillator machine) had been checked daily per the manufacturer's IFU. Findings include: 1. Observation and interview on 7/7/25 at 11:05 a.m. with director of nursing (DON) B in the Post Anesthesia Care Unit (PACU) revealed:	Q0109		

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Q0109	Continued from page 1 *One Lifepak 20 defibrillator was located on top of a crash cart. *She stated the defibrillator would complete an auto self-test daily at 3:00 a.m. and print a test strip indicating either a pass or fail result. -That test strip would then be attached to the clipboard located on top of the crash cart. *She stated a daily crash cart equipment checklist had been completed during hours of operation verifying if: -The defibrillator paddles and pads were present. -A battery check was completed. -The defibrillator was plugged into a power source. *She had been unaware of the manufacturer's IFU recommendations to complete the operator's checklist daily. Review of the manufacturer's 2015 IFU for the Lifepak 20 Defibrillator/Monitor Operator's Checklist revealed: *"1. Check auto test printed report for: -Self test failed. -Self test did not complete-Connect to test plug. *2. Inspect physical condition for: -Foreign substances. -Damages or cracks. *3. Inspect power source for: -AC power connector plugged into unit and AC power source; -AC Mains LED is lit. *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,	Q0109	Policy for Emergency Equipment has been updated to specify required daily checks for the defibrillator and the instructions for use have been added to the policy as an addendum. Board of Directors will review on 08/05/2025 for approval. Director of Nursing will complete daily checklist. Administrator will review daily checklist for July, August and September of 2025. Documentation of compliance will be included in the 3rd Quarter CQI report. Addition: On 07-08-25: All surgical staff were educated by DON with the process of checking the defibrillator daily using the checklist in the defibrillator IFU book. The Administrator will review the checklist monthly for 3 months. Benchmark to be 100% compliant for 3 months, if met then will discontinue. If benchmark not met, will continue to monitor for another 3 months.	08/05/25

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Q0109	Continued from page 2 and paddle surfaces for pitting. *6. Disconnect the defibrillator from AC power, wait 2 seconds, press ON and check for: -Momentary SELF-TEST messages, and momentary illumination of LEDs. -Services LED is lit. -LOW BATTERY/CONNECT TO AC POWER message. *7. Check ECG printer for: -Adequate paper supply. -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. -For Hard Paddles: --Confirm paddles properly seated in wells. --Select 50J and press the CHARGE button. --When fully charged press the shock button on paddles and look for ENERGY DELIVERED message. *9. Reconnect the defibrillator to AC power and then power off device." Review of the provider's 2025 Crash Cart Medication and Supplies policy revealed: *"Check the Emergency Crash Cart at least once every day and after each use. *Daily documentation regarding the examination of the Crash Cart and the verification of the integrity of the Cart is the responsibility of the nursing staff."	Q0109		

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Q0109	Continued from page 3 *The policy had not specified the required daily checks for the defibrillator.	Q0109		
Q0241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure four of four probes (specialized electrodes used to deliver targeted radiofrequency energy to destroy unwanted tissue, typically for pain management or tumor ablation) containing blood and bodily fluids had been transported in a sealed container and were labeled as biohazardous. Findings include: 1. Observation on 7/8/25 at 8:40 a.m. with registered nurse (RN) D in operating room (OR) 2 revealed: *After a procedure for patient 1, she had placed gloves on both hands and grabbed four probes that had been used during the procedure. *She proceeded to transport those contaminated probes out of OR 2 and across the hallway to the soiled holding room for decontamination. *Prior to transport, those contaminated probes had not been contained in a leak proof container or bag and labeled as biohazardous. Interview on 7/8/25 at 9:25 a.m. with RN D regarding transportation of contaminated devices from the OR to the soiled holding room revealed: *The probes used in the procedure for patient 1 needed to be reprocessed and sterilized. *She had always transported probe devices used in the OR, uncovered in her gloved hands, to the soiled holding room. *She agreed those devices would have contained blood and bodily fluids.	Q0241	Director of Nursing discussed finding with Registered Nurse responsible for transport and sterilization of probes. Director of Nursing noted that the same procedure was performed on 07/14/2025 and the Register Nurse placed the probes in a leak proof container labeled as biohazardous for transport to the soiled holding room. Director of Nursing will document dates this procedure is performed through December 31, 2025 and monitor that contaminated devises are handled properly. Director of Nursing will include documentation in the 3rd and 4th Quarter CQI reports.	07/14/25

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Q0241	Continued from page 4 *She agreed items that contained blood, and bodily fluids should have been transported in a leak proof container or bag and labeled as biohazardous. *She confirmed the provider followed the Association of Perioperative Registered Nurses (AORN) guidelines to guide their practice and to write their policies. Interview on 7/8/25 at 11:10 a.m. with director of nursing B regarding the transportation of contaminated devices from the OR to the soiled holding room revealed items that contained blood, or bodily fluids should have been transported in a leak proof container or bag and labeled as biohazardous. Review of the provider's 1/2006 Employee Exposure Control Plan Bloodborne and Airborne Pathogens Standard policy revealed: *"Regulated waste is: -Liquid or semi-liquid blood or other potentially infectious material; -Items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling. *Regulated waste will be placed in a leak proof, closable, labeled containers or bags. *Specimens of blood or other potentially infection materials shall be placed in a color coded container that prevent leakage during collection, handling, processing, storage, transport or shipping. -The specimen container shall be labeled or color-coded and closed prior to being stored, transported or shipped." Review of AORN's 2024 Guidelines for Perioperative Practice: Transport to the Decontamination Area pg. 415 revealed: *"7.2. Contaminated instruments must be transported to the decontamination area in a closed container or enclosed transport cart that is: -leak proof, -puncture resistant, -large enough to contain all contents, and	Q0241	Addition: On 07-08-25: Two biohazard leak proof containers were purchased, one for each OR room. All surgical staff were educated on 07-08-25 by DON on the process of the biohazard leak proof containers. DON will monitor every surgical day on the procedures of using the proof leak biohazard containers. Benchmark to be 100% compliant for 3 months. If benchmark not met, will continue to monitor for another 3 months.	

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Q0241	Continued from page 5 -labeled with a fluorescent orange or orange-red label containing a biohazard legend."	Q0241		