STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTIONS AND PLAN OF CORRECTIONS AND PLAN OF CORRECTIONS		IDENTIFICATION NUMBER:		A. BUILDING B. WING	07/02/2025		
NAME OF PROVIDER OR SUPPLIER Universal Pediatric Services				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 TECHNOLOGY DR , SIOUX FALLS, South Dakota, 57106			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE	
G0000	INITIAL COMMENTS A recertification health surver CFR Part 484, Subparts B-C Health Agencies, was conducted 7/2/25. Universal Pediatric Secompliance.	y for compliance with 42 , requirements for Home cted from 7/1/25 through	G0000				
	cy statement ending with an as		the ins	stitution may be excused from correcting p	roviding it is determine	ed that other	

(X2) MULTIPLE CONSTRUCTION

FORM CMS-2567 (02/99) Previous Versions Obsolete

andy such

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

participation

Event ID: 66804-H1

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

Facility ID: SD43K001

Director of Operations

07/17/2025
If continuation sheet Page 1 of 1

(X6) DATE

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTIONS A. BUILDING 07/02/2025 43K001 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

Universal Pediatric Services			4300 TECHNOLOGY DR , SIOUX FALLS, South Dakota, 57106				
(X4) ID PREFIX (E TAG RI	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EEGULATORY OR LSC IDENTIFYING INFORMATION)	PR	ID EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
A re Par Pre con	recertification survey for compliance with 42 CFR rt 484, Subpart G, Subsection 484.102 Emergency eparedness Requirements for Home Health Agencies, was nducted from 7/1/25 through 7/2/25. Universal diatric Services was found in compliance.	EOO	000				

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 reverse for further 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

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

Director of Operations

Facility ID: SD43K001

(X6) DATE 07/17/2025