STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 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
Q0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 416, Subpart C, requirements for Ambulatory Surgery Centers was conducted from 7/25/23 through 7/26/23. Rivers Edge Aesthetic Surgery was found not in compliance with the following requirements: Q0002 and Q242.	Q0000		
Q0002	DEFINITIONS CFR(s): 416.2 As used in this part: Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.The ambulatory surgical center must comply with state licensure requirements. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure: *The ambulatory surgical center (ASC) was not used to perform procedures for the attached clinic during the ASC hours of operation for seven of seven clinic patients. *The ASC's waiting area was utilized for ASC patients during the hours of operation and not the clinic waiting room for all ASC patients. Findings include: 1. Observation on 7/25/23 at 3:10 p.m. with certified surgical technologist (CST) D revealed:	Q0002	Rivers Edge Aesthetic Surgery will have their reception desk monitored during business hours for HIPAA compliance and security. During days of operation, REAS staff will monitor the reception desk until the third case of the day, then a receptionist will work for REAS until additional REAS staff become available to monitor the desk again. This staff member will open the exterior door to allow patients and their families to enter and remain in the REAS waiting room. The patients will be taken back to the pre-op area to complete consent signing and meet with nursing, anesthesia and the physician prior to surgery. The reception desk will be secured with glass to also assist in HIPAA compliance and security. DON has updated the Safety and Security policy and educated staff on August 14, 2023 that all procedure room patients must enter for surgery through REAS, be treated by REAS employees and discharged through REAS. The DON will monitor the schedule weekly to assure all patients are registered through the REAS office. The DON will monitor the schedule for 3 months to make sure all procedure room patients have been checking in at REAS, treated as a REAS patient and discharged as a REAS patient. Once this study is 100% compliant the QA will be reported to the BOG by the DON and then discontinued.	9/9/2023

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	TITLE	(X6) DATE
Jodi Pierret	Administrator	08/15/2023

RECEIVED AUG 21 2023 SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 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
Q0002	Continued from page 1 *She was in the process of disinfecting operating room (OR) 2. *They had just finished a procedure on a clinic patient in that room. -It was a local procedure and the patient had already been discharged. *There were five surgical procedures and two local procedures that had been scheduled for that day (7/25/23). *The above seven patients were client patients, but they documented care on the same paperwork as Rivers Edge ASC patients. Interview on 7/25/23 at 4:25 p.m. with administrator C confirmed: *Clinic patients were seen in the ASC in OR 2 for procedures today (7/25/23). *They were aware there should have been separation between ASC and clinic patients. -"This will be an easy fix we'll make all patients ASC patients." *Staff documented care for those patients on Rivers Edge ASC paperwork. *The waiting area in the ASC was not staffed and patients waited in the clinic waiting area. *The ASC waiting area was not "HIPAA" (Health Insurance Portability and Accountability) compliant, other patient information could be heard when in the waiting area. *She did not have enough staff to sit at the ASC register desk and monitor patient's sitting in the ASC waiting area. *Patient's check-in at the clinic registration desk, the clinic staff would let the ASC staff know they had a patient waiting. -ASC staff would then retrieve the patient and would then take them to the ASC waiting area. *The ASC waiting area was utilized as a preop area for consent signing, then patients were taken back to the	Q0002		

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Q0002	Continued from page 2 preop room where they were seen by nursing, anesthesia, and the physician. Observation on 7/26/23 at 10:40 a.m. revealed ASC patient 21 was sitting in the clinic waiting area. Director of nursing A retrieved the patient and led her into the ASC waiting area. She then proceeded to review the registration paperwork, OR consent form, and discharge instruction paperwork with patient 21.	Q0002	DON has ordered new impermeable cover gowns to replace the yellow non-impermeable cover gowns being used for PPE. All staff in this duty were re-educated by the DON on August 14, 2023 and are aware of the new impermeable gowns that are to be worn to protect their scrubs from contamination during instrument cleaning, as part of their PPE requirement. The DON will monitor the appropriate PPE use on a weekly basis for the next 3 months to make sure staff is in compliance. Once this QA meets 100% compliance this will be monitored annually. The DON will provide the QA results to the Board at the following BOG meeting. The DON will re-evaluate the PPE annually or as needed based on supply availability.	9/9/2023
Q0242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, revealed the provider failed to ensure: *All staff that worked in the instrument decontamination room wore impermeable cover gowns when cleaning contaminated surgical instruments. *Hand hygiene was performed by one of one anesthesia provider (E) after direct contact with one of two sampled patients (1) during the administration of anesthesia care. *Sterile supplies used for patient care had not touched the floor prior to use for one of two sampled patient's (2) surgical procedure. Findings include: 1. Observation on 7/25/23 at 3:26 p.m. revealed a staff member in the decontamination room placed surgical instruments in a sink filled with a cleaning solution, and then exited the room. -The staff member was wearing a mask with an attached face shield and gloves; she was not wearing a cover gown over her scrub uniform. Observation and interview on 7/25/23 at 4:00 p.m. with certified surgical technologist (CST) D revealed:	Q0242		

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Q0242	Continued from page 3 *A pack of yellow cover gowns in the instrument decontamination room. *The cover gowns were used as personal protective equipment (PPE) by staff when cleaning contaminated surgical instruments. *She was not sure if the gowns were waterproof but would ask another staff member. -CST D left the decontamination room but did not return with a response. On 7/25/23 at 4:10 p.m. testing of the gown under running water revealed the yellow cover gowns were not waterproof. The surveyor's hand had become wet when holding the sleeve of the gown under running water. Interview on 7/26/23 at 3:15 p.m. with director of nursing (DON) A confirmed the yellow gowns staff wore to protect their scrubs from contamination during instrument cleaning were not waterproof. Review of the provider's 2/25/23 Instrument Decontamination and Reprocessing policy revealed when washing instruments staff should have worn PPE that included gown, gloves, and eyewear. Review of the provider's 1/20/23 Personal Protective Equipment Policies revealed: *The "Practice administrator is responsible for the development, implementation, and administration of River's Edge Aesthetic Surgery's PPE policies according to the general CDC [Centers for Disease Control] guidelines." That involved: -"7. Periodically re-evaluating the suitability of previously selected PPE." *Supervisor and/or staff had the primary responsibility for implementing and enforcing PPE use and policies in their work areas. That involved: -"9. Providing appropriate PPE and making it available to employees." 2. Observation on 7/25/23 at 10:22 a.m. through 11:45	Q0242		

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Q0242	Continued from page 4 a.m. of certified registered nurse anesthetist (CRNA) E revealed: *Numerous opportunities of missed hand hygiene after direct patient care and not performing hand hygiene after removing gloves during the performance of anesthesia care. *After replacing patient 1's laryngeal mask airway (LMA) for a different size CRNA E at: -10:22 a.m. – Removed his gloves, put on a clean pair of gloves without performing hand hygiene and proceeded to open cabinet #1 for tape, charted, and entered the anesthesia cart to put away medications. -10:47 a.m. – Put on clean gloves, administered medication, removed gloves, and had not performed hand hygiene. -11:40 a.m. – Put on clean gloves, picked up a Chux pad from the floor, threw it in the trash, removed his gloves, no hand hygiene was performed, put on a clean pair of gloves, and checked patient 1's right arm position. *After removing the patient's LMA he changed gloves and performed no hand hygiene between glove change. Interview on 7/25/23 at 3:15 a.m. with DON A confirmed hand hygiene should have been performed after direct contact with a patient and before and after glove changes. Review of the provider's 12/2/16 Hand Hygiene Policy revealed: *"Hand Antisepsis: An alcohol hand rub will be used before contact with patients and for routine contamination of hands unless hands are visibly soiled." *Decontaminate hands before and after contact with patients. *"Decontaminate hands after removing gloves." *"Decontaminate hands if moving from a contaminated body site to a clean body site during patient care." *"Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate	Q0242	The DON re-educated CRNA E on August 14, 2023 and entire clinical staff regarding hand hygiene guidelines and the importance of hand hygiene. Hand hygiene guidelines have already been posted as a reminder. The DON will continue to monitor the entire staff daily on compliance with our hand hygiene policy and protocols. This monitoring will continue for 3 months or until it reaches 90% compliance, and will report status to the Board at the BOG meeting. Once this monitoring has reached 90% compliance the monitoring will be continued by the DON on a quarterly basis.	

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Q0242	Continued from page 5 vicinity of the patient." 3. Observation on 7/25/23 at 11:50 a.m. of CRNA E's preparation for patient 2's surgical procedure revealed: *The intravenous (IV) tubing was opened and allowed to drag on the floor prior to him spiking the IV bag. *He opened the breathing circuit and the end that attached to the face mask dropped to the floor, he proceeded to attach it to the face mask, and hung it on the anesthesia machine for later use. *He continued preparations to receive the patient. *The surveyor asked him if he was going to use those tubings. *He shook his head no, shrugged his shoulders, and discarded the IV bag and tubing; he had not changed the breathing circuit and it was used on patient 2. Interview on 7/26/23 at 3:10 p.m. with DON A confirmed items on the floor were no longer clean and should have been thrown away.	Q0242	The DON re-educate all clinical staff on August 14, 2023 to monitor patient care items that touch the floor as they are contaminated and must be disposed of. The DON will continue to monitor the staff on compliance with patient care items daily to avoid contamination. The DON will monitor the staff daily for 3 months. Once this QA has met 100% compliance the QA will be continued on a quarterly basis. All results will be reported to the BOG, by the DON, at the next Board meeting on August 30, 2023 and quarterly thereafter.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/26/2023

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 416, Subpart C, Subsection 416.54, Emergency Preparedness, requirements for ambulatory surgery centers, was conducted from 7/25/23 through 7/26/23. Rivers Edge Aesthetic Surgery was found in compliance.	E0000		

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	TITLE	(X6) DATE
Jodi Pierret	Administrator	8/8/2023

RECEIVED
AUG 09 2023
SD DOH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 57105

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K0000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing ambulatory surgical center) was conducted on 7/26/23. Rivers Edge Aesthetic Surgery was found not in compliance with 42 CFR 416.44 (b)(1) requirements for Ambulatory Surgical Centers. The building will meet the requirements of the 2012 LSC for Existing Ambulatory Surgical Center Occupancies upon correction of the deficiencies identified at K131, and K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	The Medical Director is working with a contractor to remove the existing door handle and replace it with a latching handle, as well as adjusting the door to make sure it closes and latches. After this door has been repaired, the administrator will monitor this door to make sure it closes and latches as required. This will be monitored on a weekly basis for 3 months. Once this QA meets 100% compliance the door will remain monitored annually by the administrator to make sure it meets all code requirements and fully latches closed. The administrator will report results to the BOG at the next Board meeting.	9/9/2023
K0131	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed	K0131		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodi Pierret	Administrator	8/9/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/26/2023

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K0131	Continued from page 1 position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to ensure building separation from other occupancy types for one randomly observed fire wall. Findings include: 1. Observation on 7/26/23 beginning at 10:53 a.m. revealed a 90-minute fire-rated door located in the building separation between the clinic and ambulatory surgical center. Testing of that door at that same time revealed it would strike the frame upon closing and would also not latch. All doors in fire-rated building separations are required to close and latch. Further observation at that same time revealed the doors latch bolt had been removed and therefore would not latch under any circumstance. Interview with the administrator at the time of the observation and testing confirmed that condition. She stated that door had recently received a new door handle and it stopped latching at that point. She also stated she was unaware all fire-rated doors were required to latch into the door frame.	K0131		
K0211 Bldg. 01	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 instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the	K0211		

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K0211 Bldg. 01	Continued from page 2 provider failed to ensure means of egress were continuously maintained free of all obstructions to full use in case of emergency as required at one randomly observed exit door location (West exit door). Findings include: 1. Observation on 7/26/23 at 11:29 a.m. revealed the west exit door had been provided with a barrel bolt lock across the door into the door frame. Testing of that door at that same time revealed that barrel bolt lock would lock the door shut and keep it from full use in all lighting conditions and required more than one action to exit. Interview with the administrator at the time of the observation confirmed that condition. She stated that door would not latch at certain times of the day due to heat from the sun. She further stated the barrel bolt lock was installed on that exit door so unauthorized individuals could not gain access into the building during that condition. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 20.2.1, 7.2.1.5.10	K0211	The administrator will remove the dead bolt on the west emergency exit door and adjust the door so it fully closes during all times of the day. Once this adjustment has been completed the administrator will monitor the door weekly for the next 3 months to make sure it remains in the locked and latched position and is not able to be opened from the outside. The QA will be reported to the Board, by the administrator at the next BOG meeting.	9/9/2023

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63819	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 SOUTH MINNESOTA AVE STE 111 SIOUX FALLS, SD 57105

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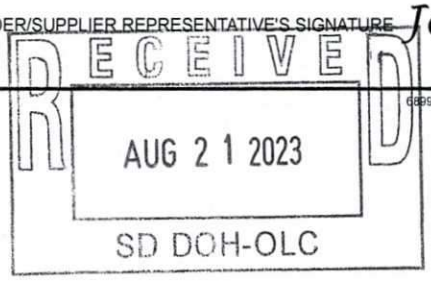
S 000	Compliance/Noncompliance A licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted from 7/25/23 through 7/26/23. Rivers Edge Aesthetic Surgery was found not in compliance with the following requirement: S135.	S 000		
S 135	44:76:07:01 Pharmaceutical Services The requirements for pharmaceutical services in ambulatory surgery centers are as follows: (1) A physician, pharmacist, or registered nurse is responsible for the supervision of drug stocks in the facility; (2) Records shall be kept of stock supplies of all drugs and shall give an accounting for all items purchased and dispensed; (3) Policies and procedures on drug handling, storing, labeling, and dispensing shall be in writing and available to personnel; and (4) All drugs in the facility shall be labeled with drug name, strength, and expiration date and shall be stored in specially designated, well illuminated cabinets, closets, or storerooms. Drug cabinets shall be accessible only to authorized individuals as outlined in the facilities policies and procedures. All drugs controlled pursuant to SDCL chapter 34-20B shall be securely locked and shall be accessible only to authorized individuals. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Medication storage for one of one procedure room (2) was not accessible to unauthorized staff. *Anesthesia medication cart keys were secured when not in the possession of the anesthesia	S 135		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jodi Pierret TITLE Administrator (X6) DATE 8/15/2023



South Dakota Department of Health

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	63819	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 SOUTH MINNESOTA AVE STE 111 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) COMPLETE DATE
S 135	Continued From page 1 provider. Findings include: 1. Observation and interview on 7/25/23 at 3:25 p.m. in operating room 2 revealed: *Certified surgical technologist (CST) D began the disinfection process after a clinic's patient procedure. *Inspection of the red medication cart revealed it was unlocked and there were fourteen vials of Xylocaine 1% in addition to medical supplies in the cart. *At the end of the cart inspection CST D locked the cart. -When asked where those keys were kept she replied "In the clinic." *CST D stated she had access to that cart because supplies were also stored in it. Review of the provider's 4/7/23 Drug Security policy revealed unlicensed personnel will not have access to any drugs. 2. Observation on 7/25/23 at 3:50 p.m. certified registered nurse anesthetist (CRNA) E was asked for access to the anesthesia cart. At that time he entered the registration desk area and retrieved the keys from the countertop and opened the cart. After review of the anesthesia cart the keys were returned to the nurse in post-anesthesia. In the registration area underneath the counter where CRNA E had retrieved the keys was a cabinet with a padlock. The nurse unlocked the cabinet and put the keys inside a bin, then relocked that cabinet. She stated the keys were always stored there. Interview on 7/26/23 at 3:15 p.m. with director of nursing (DON) A confimed the anesthesia keys were locked in a cabinet in the ambulatory	S 135	All medical supplies have been removed from the red medication cart in OR 2. The Director of Nursing will keep all keys in the lock box behind the DON desk, in the locked cabinet. The DON will account for all keys in the lock box at the end of each business day to account for accuracy and security. All unlicensed personnel do not have access to the red medication cart, locked cabinet, lock box or drug cabinet. The DON will be monitoring daily, that all keys have been placed in the lock box at the end of day as part of the end of day process. The DON re-educate all staff on August 14, 2023 on the importance of keeping all keys locked up and who has access. The DON will report the results to the Board on August 30, 2023 at their quarterly BOG meeting. This will be a continuous QA assessment and reported to the Board by the DON every quarter going forward. CRNA E was personally re-educated by the DON on August 14, 2023 to put keys in the lock box in the locked cabinet or to hand the keys off to an RN or DON to be placed in the lock box when not in use. The DON will be monitoring daily, that all keys have been placed in the lock box at the end of day as part of the end of day process. The DON will report the results to the Board on August 30, 2023 at their quarterly BOG meeting and quarterly thereafter. This will be a continuous QA assessment.	9/9/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63819	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 SOUTH MINNESOTA AVE STE 111 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) COMPLETE DATE
S 135	Continued From page 2 surgery center registration office. In the registration area, the DON demonstrated opening the padlock and placement of the anesthesia keys in the storage container.	S 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 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
Q0000	INITIAL COMMENTS An onsite revisit survey was conducted on 9/12/23 for compliance with 42 CFR Part 416, Subpart C, requirements for Ambulatory Surgery Centers, for all previous deficiencies cited on 7/26/23. All deficiencies have been corrected and no new noncompliance was found. Rivers Edge Aesthetic Surgery was found in compliance with all regulations surveyed.	Q0000		

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	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A revisit survey for compliance with the Life Safety Code (LSC) (2012 existing ambulatory surgical center) was conducted on 9/12/23. Rivers Edge Aesthetic Surgery was found in compliance with 42 CFR 416.44 (b)(1) requirements for ambulatory surgery center facilities.	K0000		

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	TITLE	(X6) DATE

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63819	A. BUILDING: _____ B. WING _____	R 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE AESTHETIC SURGERY	4201 SOUTH MINNESOTA AVE STE 111 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) COMPLETE DATE
{S 000}	Compliance/Noncompliance A revisit licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted on 9/12/23. Rivers Edge Aesthetic Surgery was found in compliance.	{S 000}		

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