STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001004	A. BUILDING B. WING	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dakota West Surgery Center	240 MINNESOTA ST , RAPID CITY, South Dakota, 57701

(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 Center (ASC), was conducted from 8/19/25 through 8/20/25. Dakota West Surgical Centers was found not in compliance with the following requirements: Q0234 and Q241	Q0000		
Q0234	CONFIDENTIALITY OF CLINICAL RECORDS CFR(s): 416.50(g) The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to implement measures to protect the privacy and confidentiality of patients' medical and financial records. Findings include: 1. Observation on 8/19/25 at 9:15 a.m. revealed: Inside the main entrance to the facility, and to the left was the ambulatory surgery center. A receptionist's office was located about ten to fifteen feet from the surgical center entrance. Looking into the receptionist's office from the receptionist's check-in counter, there was a cardboard box on a countertop with file folders in it. A locking three-drawer file cabinet had a key inserted in its lock mechanism. Upon entering the unlocked receptionist's office, the above file folders were labeled with individuals' names. A computer screen on the receptionist's desk was unlocked and had multiple file folders on it.	Q0234	Front Desk reception area will be staffed at all times. When staff is absent the computers will be locked, all patient charts/information will be put away and secured, and file cabinet will be locked and the keys securely stored. Staff education provided to all front desk personnel reguarding HIPAA compliance and the importance of securely storing patient information. Random daily audits will be completed by the DON for 2 weeks to ensure that there is a receptionist at all times or if the receptionist is not present that all patient information is secure. If audits are deemed satisfactory then will go to weekly audits. Audits will ensure that patient charts/information is stored securely, computers are locked, & file cabinets are locked and the keys securely stored. Audits will be reported to QAPI quarterly and QAPI will determine if the audits are satifactory.	9.8.2025

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
Brenda Holmberg	ASC Director	9.12.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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Q0234	Continued from page 1 Interview on 8/19/25 at 2:45 p.m. with administrative assistants E and F revealed: Their responsibilities had included filling the role of the surgery center's receptionist on scheduled surgery days. The above file folders had contained confidential patient information regarding the provider's clinic patients. The contents of those folders were in the process of being scanned. It was not known who had left that box on the countertop. It should have been securely stored if it was not being used by staff. The three-drawer file cabinet had contained patient financial information. The drawers were expected to be locked at all times, and the key securely stored when there was no staff person in that receptionist's office. Administrative assistant F confirmed that the files on the above computer screen had contained patient information. Employees were expected to lock their computer screens when their computers were not being used. Interview on 8/19/25 at 9:55 a.m. and on 8/20/25 at 8:10 a.m. with administrator A and director of nursing (DON)/infection control (IC) nurse B revealed: One of three clinic staff members shared the responsibility of working at the receptionist desk at the surgery center on the days when surgical patients were seen. There was no staff member scheduled to work at the receptionist desk on 8/19/25 because no surgery center patients were scheduled to be seen that day. It was expected that all staff had locked their computer screens if they stepped away from their computers. The key to the three-drawer metal cabinet should have been locked and the key securely stored at all times. Patient records should have been securely stored if they were not being used. The above confidential patient information had not been appropriately protected by the staff. Review of the provider's revised 3/30/23 Patient Bill of Rights policy revealed a patient had the right to "personal and informational privacy" and "confidentiality of records and disclosures." Review of the provider's revised 3/31/23 Medical Record policy revealed "Confidentiality of Patient Records:	Q0234		

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Q0234	Continued from page 2 All information about a patient shall be treated as confidential."	Q0234		
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 that medical supplies and equipment were safely stored to avoid possible contamination in one of one medical supply refrigerator freezers, one of one soiled utility rooms, two of three pre-operative stations, one of two post-operative stations, and one of two surgical suites. Findings include: Observation and interview on 8/19/25 from 10:00 a.m. to 10:30 a.m. during the initial tour of the surgical center with director A and director of nursing (DON)/ infection control (IC) nurse B revealed: *The medical supply refrigerator freezer located in the pre-operative/post-operative area was used to store various patient cooling gel eye pads, cold packs, frozen patient surgical supplies, and a sterile malignant hyperthermia (a rare but potentially life-threatening genetic disorder triggered by certain anesthetic agents and muscle relaxants) kit. -In the freezer door shelf, there was a used cooling gel eye pad that had a piece of tape with a person's name written on it. DON/IC nurse B stated, "That's [for] one of my nurses who gets hot." -On the top shelf of the freezer was a small plastic container that held an unopened package labeled 'Biotissue, amniotic membrane. Sterile.' Leaning up against the sterile package of biotissue were two packages of lemon-glycerine mouth swabs. One package was opened, unsealed, and contained one of three mouth swabs. *The soiled utility room, located in the post-operative area by the nurses' station, contained a large rolling bin that was full of soiled patient linens. That room	Q0241	Cooling gel eye pad with staff's name was removed & disposed of on 8.19.2025. Open package of lemon-glycerin swabs were removed & disposed of on 8.20.2025. Staff educated on disposing of lemon-glycerin swabs after opening. Staff educated on 9.10.2025 by DON regarding not placing any other items in with the package of "Biotissue, amniotic membrane, sterile." The employees who were not present that day were educated one on one with the DON by 9.15.2025. Weekly audits will be done by the DON to ensure that there are no personal items or open packages of lemon-glycerin swabs in the freezer. After 2 months of weekly audits, if deemed satsifactory, this area will be added to our monthly environmental audits. Audits will be reported to QAPI quarterly by the DON and QAPI will determine if the audits are satsifactory. Fabric umbrella in the soiled linen room was removed on 8.19.2025. Large rolling plastic cart & large metal doored cabinet have been removed from the soiled linen room on 8.19.2025. Oxygen tank with attached oxygen extension tubing was removed from the soiled linen on 8.19.2025. Opened extension tubing was removed and disposed of. Oxygen tank was taken back to the gas room to be filled. Staff were educated on 9.10.2025 by the DON regarding items in the soiled laundry area. Any staff that were not present were educated one on one by 9.15.2025 by the DON There will be weekly audits completed by the DON for 2 months to ensure that only soiled linens are present. Once deemed satisfactory then this item will be added to the monthly environmental audit. Audits will be reported to QAPI quarterly by the DON and QAPI will determine if the audits are satisfactory. Removed single use extension tubing from the pre op bays 1 and 2, and OR 2 on 8.19.2025. Staff educated on single use items. Each patient's oxygen cannulas will be attached to the wall mounted oxygen portals. Oxygen administration policy revision stating nasal cannulas are to be connected directly to the oxygen portal and no extension tubing will be used. Staff were educated on 9.10.2025 by the DON regarding O2 extension tubing and the process of attaching nasal cannulas to be connected directly to the oxygen portal. Staff that were not present on 9.10.2025 were educated one on one by 9.15.2025 by the DON. Audits will be done weekly by the DON for 2 months, to ensure that single use items are being used as a single use item. Once deemed satsifactory then this item will be added to the monthly environmental audit. Audits will be reported to QAPI quarterly by the DON and QAPI will determine if the audits are satisfactory.	9.15.2025

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Q0241	Continued from page 3 also contained a fabric umbrella in the corner behind the hopper (a washing bowl with a spraying wand used to rinse soiled items and linens of body fluids), an uncovered large rolling plastic cart, an oxygen tank with attached oxygen extension tubing, and a large metal doored cabinet which contained various items including training supplies, holiday decorations, metal lubricant spray, office supplies, and a plastic tub of unopened patient oxygen nasal cannulas and tubing. *Two of the three pre-operative stations closest to the nurse's area had unpackaged oxygen extension tubing attached to the wall-mounted oxygen portals and draped across the adjacent cabinets. -Next to the pre-operative patient station, there was a rolling computer stand that had a cardboard box lid, covered with contact (a flexible, self-adhesive material often made of vinyl) paper on the outside surfaces, sitting on top of the stand. DON/IC nurse B stated that the box lid was used by a certified registered nurse anesthetist (CRNA) to place her laptop on. She verified that the inside of the cardboard box lid was not a cleanable surface and stated, "I should throw it away." *The second post-operative station cabinet drawer contained multiple rolls of used medical tape, unopened elastic disposable dressing wraps, and a plastic container of opened unsterile gauze. Sitting on top of the tape was a plastic handheld mirror, and next to the container of gauze was a handheld folding fan made of unwashable fabric. The mirror was used by multiple patients to view their surgical sites, and the fan was used by multiple patients to cool themselves. -DON/IC nurse B stated that staff go through the cabinets and drawers once a month for cleaning, organizing, and checking for outdated items. Further observation and interview on 8/19/25 from 12:45 p.m. to 2:20 p.m. with surgical tech/registered nurse (RN) C and administrator A of the two surgical suites, the soiled utility room, and the pre-and post-operative areas revealed: *Administrator A explained that the items located in the soiled utility room were there because it was what they had always done, and they did not know where else to put those items. She verified that the umbrella was used to escort patients to their vehicles on rainy	Q0241	Cardboard box lid (covered with contact paper) removed on 8.19.2025. Staff educated on not having cardboard in the ASC. Removed the mirror from the post-operative drawer that contained clean supplies on 8.20.2025. Removed and disposed of the fabric fan from the post operative drawer that contained clean supplies on 8.20.2025. All staff were educated on 9.10.2025 by the DON regarding keeping non-wipeable items out of the ASC. Staff that were not present on 9.10.2025 were educated one on one by 9.15.2025 by the DON. There will be weekly audits completed by the DON for 2 months to ensure that non wipeable items are not present. Once deemed satisfactory then this item will be added to the monthly enviornmental audit. Audits will be reported to QAPI quarterly by the DON and QAPI will determine if the audits are satisfactory. Policy regarding single use items was created on 9.8.2025 by the DON and ASC Director. Educated the staff on regarding single use items on 9.10.2025 by the DON. Staff that was not present on 9.10.2025 was educated one on one by the DON by 9.15.2025, this includes physicians. This policy was presented to the governing board by the DON on 9.15.2025 and approved.	

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Q0241	Continued from page 4 days, the oxygen tank was from a surgical suite that was not in use, the plastic rolling cart was used for various purposes, and the metal cabinet had always been there. -She acknowledged that those items should not be stored in the soiled utility room. *Surgical tech/RN C stated that the oxygen extension tubing in the pre-operative stations was used because the nasal cannula (flexible tubing with prongs to deliver oxygen through the nose) tubing was not long enough to reach from the oxygen portal to the patient. She stated they hooked up the patient's nasal cannula to the extension tubing, and the extension tubing was not changed or cleaned between patients. The directions on the extension tubing package stated it was for "single use only." *A tour of surgical suite number 2 revealed there was unpackaged oxygen extension tubing hooked up to a cart-mounted oxygen portal. Surgical tech/RN C stated this was also not changed or cleaned between patients. -She confirmed that was not a good infection control practice and stated, "It's what they have always done here." Interview on 8/20/25 at 10:45 a.m. and walking tour of the pre- and post-operative areas with DON/ IC nurse B regarding the above findings revealed: *She was the designated infection control director, and she completed monthly infection control audits of the surgical center. -Her staff were assigned to clean and organize the pre- and post-operative sites once a week. *She confirmed: -The mouth swabs should not have been kept in the same container as the sterile amniotic membrane tissue, and the staff's cool packs should not have been stored in that freezer. -Nothing should have been stored in the soiled utility room other than soiled linens or soiled items waiting to be cleaned. -Oxygen extension tubing was packaged for single-patient use only and should not have been reused	Q0241		

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	43C0001004	A. BUILDING B. WING	08/20/2025

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Q0241	Continued from page 5 on multiple patients. -The patient mirror should not have been stored laying on top of the tape, and the handheld fan was not washable and should not have been in use. Review of the provider's January 2023 Infection Control and Prevention Program policy revealed regular on-site audits were to be conducted to monitor for compliance with standard precaution procedures. Review of the provider's April 2023 Storage of Clean Supplies and Equipment policy revealed that clean supplies were to be placed in proper clean storage areas, and items intended for one-time use are never to be reused. Review of the provider's March 2023 Oxygen Administration policy revealed there was no direction given on the use of oxygen extension tubing or nasal cannulas.	Q0241		

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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 on 8/20/25. Dakota West Surgery Center was found not in compliance. The building will meet the requirements of the 2012 LSC for Emergency Preparedness for existing ambulatory surgery center occupancies upon correction of deficiencies identified at E004 and E009 in conjunction with the providers commitment to continued compliance with the fire safety standards.	E0000		
E0004	Develop EP Plan, Review and Update Annually CFR(s): 416.54(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of	E0004	Reviewed emergency preparedness plan on 9.11.2025 by DON and ASC Director. There were no updates to the emergency preparedness plan, plan will be reviewed and updated every 2 years. Will review and report to QAPI and the governing board at the next meeting then annually thereafter.	9.11.25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Holmberg	ASC Director	9.12.2025

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E0004	Continued from page 1 this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to review the emergency preparedness plan at least every two years. Findings include: 1. Record review on 8/20/25 at 3:30 p.m. revealed the emergency preparedness plan had last been signed off as being reviewed on 3/31/23. Interview with the administrator and the director of nursing, infection control confirmed that finding. The deficiency affected one of numerous requirements for emergency preparedness.	E0004		
E0009	Local, State, Tribal Collaboration Process CFR(s): 416.54(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal	E0009		

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E0009	Continued from page 2 emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to include a process for cooperation and collaboration with local, regional, or state emergency preparedness officials to maintain an integrated response during a disaster or emergency situation and document participation in such events. Findings include: 1. Record review on 8/20/25 at 3:30 p.m. revealed the provider held a facility tornado disaster training on April 17, 2025 but not a community-based training due to a healthcare coalition scheduled session being cancelled on March 25, 2025. Interview with the administrator and the director of nursing, infection control at the time of the record review confirmed that finding. The deficiency affected one of numerous requirements for emergency preparedness.	E0009	Attending a community based HazMat DeCon Training on 9.25.2025 at Monument Hospital. This training is facilitated by the emergency preparedness coordinator at Monument Health. Will participate in at least 1 community based disaster or emergency situation annual going forward. Will document and file each participation in the emergency preparedness binder. Will document and file participation in the emergency preparedness binder. Will report participation of this exercise at the next QAPI and governing board meeting in October then annually thereafter.	9.25.2025

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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 8/20/25. Dakota West Surgery Center was found not in compliance with 42 CFR 416.44 (b)(1) requirements for ambulatory surgery center facilities. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery center occupancies upon correction of deficiencies identified at K211, K223, K345, K712, and K915 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0211	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 and interview, the provider failed to maintain egress requirements by keeping combustible storage in the vestibule of the north exit. Findings include: 1. Observation on 8/20/25 at 1:30 p.m. revealed the north exit vestibule contained a large amount of combustible items. The vestibule contained two 55 gallon plastic drums with waste paper, 9 two-feet square cardboard boxes of surgery supplies, and ten cardboard boxes of surgical water supply. Interview with the administrator and the director of	K0211	Removed all cardboard boxes of supplies and plastic trash receptacles from the north exit vestibule on 9.9.2025. There has been a change of use requested to change the back small storage room into a soiled utility room for waste. All items stored in the small back storage room will be relocated to the large storage room. There will be weekly audits completed by the ASC Director for 2 months to ensure that no items are in the egress hallway. Once deemed satsifactory then this item will be added to the monthly environmental audit. Audits will be reported to QAPI quarterly and QAPI will determine if the audits are satisfactory.	9.9.2025

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
Brenda Holmberg	ASC Director	9.12.2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dakota West Surgery Center	240 MINNESOTA ST , RAPID CITY, South Dakota, 57701

(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
K0211	Continued from page 1 nursing, infection control at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for egress.	K0211		
K0223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain one of one sets of operational self-closing fire-rated doors separating the surgery area from the recovery area. Findings include: 1. Observation on 8/20/25 at 4:10 p.m. revealed the north cross-corridor ninety-minute fire-rated doors separating the surgery area from the recovery area were equipped with top and bottom latching hardware and closers. The east door would not self-close and latch when the fire alarm was activated and the doors were released to close from the magnetic hold-opens. Interview with the administrator and the director of nursing, infection control at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for self-closing doors.	K0223	North cross-corridor doors latching hardware was adjusted on 9.5.2025 by Harvey's Lock & Security. The east door self closes and latches when the door is released from the magnetic hold-opens. When monthly life safety audits are completed and documented, the monthlymagnetic door release will be pushed to ensure that thedoors self-close and latch. If there are issues with the door then a maintenance form will be completed and Harvey's will be contacted. During fire drills the doors will be monitored to confirm that the doors self close and latch and documented.	9.5.2025
K0345	Fire Alarm System - Testing and Maintenance	K0345		

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K0345	Continued from page 2 CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to provide documentation of smoke detector sensitivity values from 2024 to 2025. Findings include: 1. Record review on 8/20/25 at 3:20 p.m. revealed an annual fire alarm inspection occurred on 6/23/25. The inspection report did not list any smoke detector sensitivity values, only pass/fail notations. Smoke detector sensitivity values are required. Interview with the administrator and the director of nursing, infection control at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for maintaining the fire alarm system.	K0345	Rapid Fire Protection (Pye-Barker Fire) was contacted to complete the smoke detector sensitivity values testing. Will have them provide documentation of the values for 2025. Going forward will have the smoke detector sensitivity values completed annually. After testing is complete, smoke detector testing will be filed in the emergency preparedness binder. The results will be reported to QAPI annually.	10.1.2025
K0712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 This STANDARD is NOT MET as evidenced by:	K0712	Retreived records from another file that there were fire drills completed in 9.22.2023, 2.27.2024 in addition to the dates listed. These fire drills were added into the drill section of the emergency preparedness binder with the other fire drills. Will conduct fire drills in the first month of each quarter starting in October 2025 to ensure that all fire drills are completed within 3 months of each other. Will be cognizant that the fire drills are filed in the correct area when completed. All completed fire drills will be reported and reviewed by QAPI quarterly.	10.1.2025

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K0712	Continued from page 3 Based on observation and interview, the provider failed to conduct fire drills on a quarterly basis from November 2023 to August 2025. Findings include: 1. Record review on 8/20/25 at 3:20 p.m. revealed the provider operated on one shift. The fire drill documentation indicated drills were held on 11/17/23, 5/1/24, 9/4/24, 11/5/24, 3/25/25, and 8/7/25. The drills were not held on a quarterly basis (every three months). Drills were held at five months, four months, two months, five months, and four months. Interview with the administrator and the director of nursing, infection control at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for conducting fire drills.	K0712		
K0915 Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to document monthly load run percentage of	K0915	Contacted Butler Machinery Company, the Olympian G100F3 generator is natural gas powered. Requested the reports regarding the monthly percent load of the generator. Once the reports have been recieved then will file the reports in the emergency preparedness binder with the other Butler reports. These reports will be documented monthly. Will report the monthly percent load of the generator to QAPI quarterly.	10.1.2025

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K0915 Bldg. 01	Continued from page 4 nameplate value for the generator or otherwise have an annual load bank conducted for calendar year 2024 and 2025. Findings include: 1. Record review on 8/20/25 at 3:20 p.m. revealed the diesel powered Olympian G100F3 generator was run under load monthly. There was no documentation stating what percent load the generator carried during those monthly tests for calendar year 2024 and 2025. The generator must be loaded a minimum of 30 percent of the nameplate value otherwise an annual load bank must be performed. Interview with the facility director and the director of nursing and operations at the time of the observation confirmed those findings. The deficiency affected one of numerous requirements for maintaining the essential electrical system generator.	K0915		

South Dakota Department of Health

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DAKOTA WEST SURGERY CENTER	240 MINNESOTA ST RAPID CITY, SD 57701

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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 centers, was conducted from 8/19/25 through 8/20/25. Dakota West Surgery Center was found not in compliance with the following requirements: S0097 and S0101.	S 000		
S 097	44:76:04:07 Employee Health Program The facility shall have an employee health program for the protection of the patients. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and a tuberculin skin tests or blood assay test. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of patients and fellow employees may not return to duty until they are determined by a physician, physician ' s designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review and interview, the provider failed to ensure six of eight employees C, D, G, H, I, and J) reviewed were evaluated for a reportable communicable disease by a licensed health professional prior to assignment of duties or within 14 days of their hire.	S 097	Employee Health Policy has been updated by the DON to reflect that all staff and providers are free from communicable diseases prior to the assignment of duties or within 14 days of hire. This policy was updated on 9.11.2025. This policy change was presented to the governing board by the DON for approval and approved on 9.15.2025. Current employees will be asked to complete a disclosure form indicating that they are free of all communicable diseases by 9.30.2025. Results of the comminicable disease disclosure will be added to the employee file. Staff were educated on the new Employee Health Policy changes by the DON on 9.10.2025. Physicians and other staff that were unavailable were educated one on one, including a copy of the new policy. All staff including physicians had been educated as of 9.15.2025. Employee Health Policy has been updated to include that part of the credentialing process that all physicians will be required to have a physical evalulation from a licensed health care professional stating that they are free from any communicable diseases. This policy was updated by DON and the ASC director on 9.9.2025 and approved by the governing board on 9.15.2025. Current physicians will be seen by a licensed health care professional by October 1, 2025 to indicate that they are free of all communicable diseases. Results of the physical and the communicable disease disclosure will be added the employee file.	10.1.2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Hohnberg

TITLE: ASC Director

(X6) DATE: 9.12.2025

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S 097	Continued From page 1 Findings include: 1. Review of employees C, D, and H's Employment Physical Exam forms revealed: *Employee C was hired on 7/3/23. *Employee D was hired on 7/1/24. *Employee H was hired on 6/3/24. *No evaluation was completed by a licensed health professional to ensure they were free from any reportable communicable diseases. 2. Review of employees G, I, and J's employee files revealed: *Employee G was hired on 4/12/23. *Employee I was hired on 8/4/22. *Employee J was hired on 4/12/23. *There was no Employment Physical Exam form in their files and no other documentation to support they had been evaluated by a licensed health professional to ensure they were free from any reportable communicable disease. Interview on 8/20/25 at 2:42 p.m. with director of nursing B revealed: *She was not aware that all of the staff should have been evaluated by a licensed health care professional to ensure they were free from any communicable diseases prior to assignment of duties or within 14 days of hire. *The provider did not have an employee health policy to support this requirement.	S 097	Quarterly, CDC and CMS guidelines regarding communicable diseases and employee health will be reviewed by the DON and any changes will be made to our policies and procedures. These changes will be presented for approval to the governing board and QAPI by the DON. Audits of employee files will be done yearly by the DON to ensure that all employee files are up to date regarding employee health and communicable diseases. A checklist regarding all the current guidelines will be filled out on each employee with the dates that the items were completed. If there are any changes in the guidelines then the employee files will be audited an additional time to ensure that they are up to date with the most current guideline. The results of these audits will be presented to QAPI yearly by the DON. New employee files will be audited one week after employment to ensure that all items for employee health are completed or scheduled to be completed within 14 days of hire. The auditing checklist will be completed on new employee files at 14 days of hire by the DON. These audits will be presented to QAPI by the DON on an as needed basis when there are new employees hired.	
S 101	44:76:04:10(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers are as follows: (1) Each new healthcare worker shall receive the two-step method of tuberculin skin test or a TB	S 101		

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S 101	Continued From page 2 blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review, policy review, and interview, the provider failed to ensure six of eight employees (C, D, G, H, I, and J) reviewed had a documented two-step tuberculosis (TB) skin test or a TB blood assay test administered within 14 days of their employment. Findings include: 1. Review of the above listed employee files revealed: *Employee C was hired on 7/3/23. -There was no documentation in her file to support a two-step TB skin test was completed upon hire. *Employee D was hired on 7/1/24. -There was no documentation in her file to	S 101	TB Risk Asssessment Policy was reviewed and updated by the DON and ASC Director on 9.10.2025. The updated policy was presented to the governing board on 9.15.2025 and approved. For all future employees there will be a 2 step TB test completed within 14 days of hire to establish a baseline or any 2 documented TB skin tests with a 12 month date of hire, will be considered adaquate. All current staff that did not have 2 step TB test with 14 days of hire will be given a 2 step TB test by 9.30.2025. Results of the 2 step TB test will be added to the employee file. All staff were re-educated on the TB testing process and the policy was reviewed. All TB tests results will be reported to QAPI on an annual basis or upon hire of a new employee. Quarterly the DON will review the CMS and CDC guidelines regarding any changes to TB testing and risk assessments. If there are any changes the DON will update the TB Risk Assessment Policy and present to the governing board for approval. Yearly audits will be done on employee files, a checklist indicating that a TB 2 step test has been done within 14 days of hire and annual TB risk assessments for each employee thereafter. The DON will be auditing the employee files annually to ensure that the files are compliant with the latest regulations. These audits will be reported to QAPI annually by the DON.	9.30.2025

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S 101	Continued From page 3	S 101		

support a two-step TB skin test was completed upon hire.
*Employee G was hired on 4/12/23.
-The first step of her two-step TB skin test was administered on 5/16/23. There was no documentation to support that the second step of that TB test was administered.
*Employee H was hired on 6/3/24.
-The first step of her two-step TB skin test was administered on 2/24/24. That was approximately four months prior to her hire date.
-That TB skin test was documented as read on 7/26/25. That was approximately one year and five months after it was administered.
*Employee I was hired 8/4/22.
-There was no documentation in her file to support a two-step TB skin test was completed upon hire.
-She had yearly TB risk assessments completed on 7/27/23, 7/10/24, and 7/8/25.
*Employee J was hired on 4/12/23.
-The first step of her two-step TB skin test was administered 22 days after her hire date on 5/5/23.
-There was no documentation to support the second step of that TB test was administered.

Interview on 8/20/25 at 9:10 a.m. with the director of nursing B regarding the above employee TB skin tests revealed:
*She was aware that the TB skin test should have been completed within 14 days of their hire date.
*She was not sure what happened with employee H's dates for the TB skin test.
*She stated that the staff were required to have a TB skin test completed upon hire.
-Employee I should have had a TB skin test upon hire before initiating the completion of a yearly TB risk assessment.
-The TB risk assessments should not have been

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S 101	Continued From page 4 completed prior to having a TB skin test completed. That assessment was dependent upon the test results from the initial TB skin test in order to be completed every year thereafter. *She stated, "Per our policy we only do one test [TB skin test] upon hire. Review of the provider's 1/1/23 Airborne Precautions and TB Risk Assessment policy revealed: *"Each new employee will receive a two-step tuberculin skin test (TST) or a TB blood assay test (BAMT) with 14 days of employment or provide documentation of a BAMT or two TST within the previous 12-month period unless documentation of a previous positive reaction is provided. Subsequent TB testing will be based on the annual risk assessment category and known exposure events. Serial screening and testing are not recommended for facilities that remain at low-risk settings. *Documentation of employee screening and exposure will be maintained in [the] employee personnel files."	S 101		