STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENDOSCOPY CENTER, INC	2820 MT RUSHMORE ROAD , 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 Centers (ASC), was conducted from 9/13/23 through 9/15/23. The Endoscopy Center, Inc was found not in compliance with the following requirement: Q181.	Q0000		
Q0181	ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Medications were properly secured and not accessible to unauthorized individuals for four of four (emergency crash cart, cabinet directly behind nurses' station, medication refrigerator, and procedure rooms) medication storage areas. *The locked box used to store keys to medication storage areas was not left open and unattended. Findings include: 1. Observation and interview on 9/14/23 at 2:37 p.m. of the crash cart with registered nurse (RN) H revealed the cart was unlocked. Opening of the drawers revealed the following medications: *Atropine sulfate one 10 milliliter (ml) prefilled syringe. *Epinephrine injection one 10 ml prefilled syringe. *Glucagon four emergency kits. *Lidocaine two 5 milligram (mg) ampules.	Q0181	On 9/18/2023 staff educated on the need to ensure only authorized staff have access to crash cart medications and crash cart must remain locked at all times unless in use. Staff educated that key for crash cart will remain in the lock box. Opening duties updated and "unlock crash cart" removed. Closing duties updated to state "Make sure crash cart is locked". Opening and closing duties checked daily by Charge Nurse or Director for completion. Crash cart checked daily by Charge Nurse and Director the first two weeks after the initial change and then weekly for the remainder of 2023. The results of the Crash Cart Monitoring will be reported by the Director to the QA committee at the quarterly meeting for Q3 and Q4 only unless the QA committee feels continued monitoring and reporting is warranted. On 10/3/23 daily opening duties updated to state "Check defibrillator/crash cart & lock".	10/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leslie Messenger Leslie Messenger	Director	10/06/2023 10/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2023

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Q0181	Continued from page 1 *Furosemide two 10 ml vials. *Glycopyrrolate two 1 ml vials. *Dexamethasone sodium phosphate one 1 ml vial *Nitroglycerin tablets one bottle. *Naloxone two 1 ml vials. *Diphenhydramine three 1 ml vials. *Verapamil five 2 ml vials. *Albuterol one inhaler. *Calcium chloride ten prefilled syringes. *Sodium bicarbonate one 50 ml vial. *Aspirin one bottle. *Normal saline four intravenous bags. Interview with RN H confirmed the crash cart was opened at the beginning of each workday and locked at the end of the workday for "quick access and don't have to worry about finding the key." 2. Observation on 9/14/23 at 3:05 p.m. of the medication refrigerator revealed it was unlocked and the following medications were inside: *Rocuronium ten 5 ml vials. *Diltiazem ten 5 ml vials. *Humulin R insulin four vials. *Vasostrict two 1 ml vials. *Flublok five syringes *Flulaval vaccine two 0.5 ml vials. Interview on 9/14/23 at 3:05 p.m. with RN H confirmed the medication refrigerator was never locked and there was no locking mechanism on that refrigerator. Any individual during the day and after hours would have had access to those medications. 3. Observation on 9/14/23 at 3:10 p.m. revealed lidocaine 2% ten boxes ten vials per box, a total of 54	Q0181	On 9/18/23 staff educated on the need to ensure only authorized staff have access to medication refrigerator and it must remain locked at all times unless in use. On 9/22/2023 Premium Refrigerator Lock installed on medication refrigerator by maintenance. Staff educated that key for refrigerator is in lock box. On 10/3/23 closing duties updated to state "Make sure Medication refrigerator is locked". Opening and closing duties checked daily by Charge Nurse or Director for completion. Medication refrigerator checked daily by Charge Nurse and Director the first two weeks after the initial change and then weekly for the remainder of 2023. The results of the Medication Refrigerator Monitoring will be reported to the QA committee by the Director at the quarterly meeting for Q3 and Q4 only unless the QA committee feels continued monitoring and reporting is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2023

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Q0181	Continued from page 2 boxes. Interview with RN L immediately after the above observation confirmed: *It was the responsibility of the RNs to unlock medication storage areas at the beginning of the day. *The cabinet that stored the lidocaine was unlocked at the beginning of the day and locked at the end of the day. *The keys to the medication storage areas were kept in a lock box on the wall next to the automatic medication dispenser. 4. Observation on 9/15/23 revealed: *At 7:36 a.m. the crash cart was unlocked and all above listed medications were accessible. *At 7:53 a.m. the lock box on the wall next to the automatic medication dispenser was open. Inside were keys to different storage areas in the facility to include the crash cart and the Propofol storage. Interview at the time of the key lock box observation with certified nurse anesthetist G confirmed he had opened that lock box and had forgotten to relock it. *At 2:18 p.m. and 2:58 p.m. in procedure room 2 and 3 in the cabinets above the countertop were two boxes of 50% Dextrose prefilled syringes. Interview on 9/15/23 at 2:58 p.m. with RN H confirmed the 50% Dextrose prefilled syringes were kept in each procedure room in case a patient "gets hypoglycemic." 5. Interview on 9/15/23 at 8:31 a.m. and again at 9:24 a.m. with the facility director confirmed: *Medications should not have been accessible to unauthorized individuals. *She was not able to locate a policy that addressed medication security. *The crash cart had always been opened at the beginning of the day and locked at the end of the day. *She was not aware the lidocaine was stored in the cabinet behind the nurse's station was not locked. -There was not always a staff member sitting at the nurse's station. *Her review of the facility's medication administration	Q0181	On 9/18/23 staff educated on the need to ensure only authorized staff have access to medication cabinets and they must remain locked at all times unless in use. On 10/3/23 opening duties updated to state "Make sure all nurse's station cabinets are locked". Closing duties previously included ensuring all cabinets are locked. Opening and closing duties checklist checked daily by Charge Nurse or Director for completion. Medication cabinets checked daily by Charge Nurse and Director the first two weeks after the initial change and then weekly for the remainder of 2023. The results of the Medication Cabinet Monitoring will be reported to the QA committee by the Director at the quarterly meeting for Q3 and Q4 only unless the QA committee feels continued monitoring and reporting is warranted. On 9/18/23 re-educated staff on the importance of ensuring the key lock box remains locked at all times and medications are only accessible to authorized staff. Sign placed on lock box stating "Lock me before you leave me". On 9/20/23, medications in cabinet in procedure rooms moved to nurse lock drawer in procedure rooms. Medications no longer stored in the unlocked cabinet in procedure rooms. Key for lock drawer assigned to a cubie in the cubex so key is checked out and back in with each procedure and nurse. Key lock box, procedure room cabinets (to ensure remain drug free) and nurse lock drawer checked daily by Charge Nurse and Director the first two weeks after the initial change and then weekly for the remainder of 2023. The results of the Key Lock Box, Procedure Room Cabinets and Nurse Lock Drawer Monitoring will be reported to the QA committee by the Director at the quarterly meeting for Q3 and Q4 only unless the QA committee feels continued monitoring and reporting is warranted. On 9/18/23 staff educated on the need to ensure only authorized staff have access to medications. Policy on Medication Security is in the process of development and will be completed and assigned to staff for review and acceptance by 10/20/23. Policy will address that medications will only be accessible to authorized individuals, that all areas of medication storage must remain locked when not in use, and that the key lock box must remain locked at all times when not in use. Policy is being developed in compliance with federal and state requirements. Administration of Drugs will be added to QA committee agenda as a standing item for at least one year and until the QA committee determines it no longer needs to be a standing item as to ensure standards are monitored and met and to identify and discuss opportunities for improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001015	A. BUILDING B. WING	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q0181	Continued from page 3 policy did not state medications should not be accessible to unauthorized individuals. *The medication key lock box should not have been left open to prevent unauthorized access.	Q0181		

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	43C0001015	A. BUILDING B. WING	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments A recertification health survey for compliance with 42 CFR Part 416, Subpart C, Subsection 416.54, Emergency Preparedness, requirements for ambulatory surgery centers (ASC), was conducted from 9/13/23 through 9/15/23. The Endoscopy Center, Inc 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
Leslie Messenger	Director	09/27/2023

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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
	40958 S	A. BUILDING: _____ B. WING _____	09/15/2023

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THE ENDOSCOPY CENTER, INC	2820 MOUNT RUSHMORE RD 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 services, was conducted from 9/13/23 through 9/15/23. The Endoscopy Center, Inc was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Leslie Messenger TITLE Director (X6) DATE 10/06/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/14/2023

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K0000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/14/23. The Endoscopy Center, Inc. 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 K511 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
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		

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
Leslie Messenger OCT 06 2023	Director	10/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/14/2023

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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: 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 shall not have less than a one 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 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. LSC 21.1.3.3, 21.3.7.1 Based on observation and interview, the provider failed to ensure the one-hour fire-rating of the separation wall between the ambulatory health care and the receiving area for the rest of the tenants of the building (locker room wall). Findings include:	K0131		

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K0131	Continued from page 2 Observation on 9/14/23 at 1:30 a.m. revealed there was a one-hour fire-rated wall separating the ambulatory health care (ASC) occupancy from the receiving dock area for the tenants of the rest of the building. The wall had insulated pipe penetrations above the lay-in ceiling through the one-hour wall that were unsealed from the receiving area to the ASC locker rooms. The unsealed area was approximately six inches by six inches. Interview with the maintenance technician revealed the lines were most likely for an air conditioning system installed in the locker rooms. The deficiency could affect 100% of the occupants of the smoke compartment.	K0131	On 9/18/23 maintenance sealed pipe penetrations in six inch by six inch area with fire rated caulking. On 9/29/23 area inspected by Director, maintenance and Construction company and confirmed pipe penetrations above lay-in ceiling through one-hour fire rated wall in six inch by six inch area were sealed with red fire rated caulking. Remaining parameters of fire rated wall separating the ASC from other entity checked above the lay-in ceiling by Construction Company, Maintenance and Director. Compliance will be monitored quarterly by Director and Maintenance through checking all parameters above the lay-in ceiling of this fire rated wall separating the facilities and Director will report to the QA Committee via the QA Dashboard for Q3 and Q4 of 2023 only unless the QA Committee feels further monitoring is warranted.	9/29/2023
K0511 Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 21.5.1.2, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. LSC 20.5.1 The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (A)(1)(b), or (A)(1)(c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are encased. NFPA 70, Section 110.26(A)(1) Working space required by this section shall not be used for storage. NFPA 70, Section 110.26(A)(1)(B) Based on observation and interview, the provider failed to maintain three feet of clear working space in front of the electrical panels in one of one area (the main electrical room). The provider must comply with the National Fire Protection Association (NFPA 70),	K0511	The Director will note on the Dashboard the location that was checked, findings, and date the penetration was sealed if any areas are found that need correction. The Board of Directors reviews the QA Committee meeting minutes quarterly.	

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	43C0001015	A. BUILDING 01 - MAIN BUILDING 0... B. WING	09/14/2023

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K0511 Bldg. 01	Continued from page 3 National Electrical Code (NEC) article 110.26(A)(1) Depth of Working Space (see attachment). Findings include: 1. Observation at 1:30 p.m. on 9/14/23 revealed the electrical panels in the main electrical room were obstructed by a floor scrubber, scrubber parts, janitor mop bucket, mops, carts, plastic barrels, and related janitorial equipment. The floor was marked with tape to show the clear working space required. There was not a minimum three feet of clear working space provided at any electrical panel in the room. The electrical room was being used as a housekeeping storage room. Interview with the maintenance technician at the time of the observation confirmed that finding. The deficiency affected one of many electrical code requirements.	K0511	On 9/18/23 Housekeeping re-educated on need to ensure a minimum of three feet of working space around electrical panels is required and all items must be placed outside of tape on floor. Housekeeping moved large items including floor scrubber and janitor carts with mop buckets and mops outside of tape on floor. Housekeeping and COO actively creating new storage space on 3rd floor for remaining housekeeping items. On 10/2/23 Director and Maintenance confirmed carts and mop buckets and mops outside of tape and additional storage space identified on 3rd floor is still in the process of being cleared out for housekeeping. On 10/6/23 COO and Director confirmed created storage space on 3rd floor is ready, all housekeeping items with the excpetion of the carts moved to this location, carts are placed outside of tape, and there is three feet of clear working space around electrical panels with no remaining items within tape on floor. Compliance will be monitored weekly for the first two weeks by Maintenance and Director and then monthly thereafter for six months, unless the QA committee determines further monitoring is warranted. Compliance will be reported by Director to the QA committee at the quarterly meetings covering the monitoring period via the QA Dashboard. The Director will note on the Dashboard the date of inspection, findings, and correction of indicated. The Board of Directors reviews the QA Committee meeting minutes quarterly.	10/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001015	A. BUILDING B. WING	10/26/2023

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Q0000	INITIAL COMMENTS An onsite revisit survey was conducted on 10/26/23 for compliance with 42 CFR Part 416, Subpart C; requirements for Ambulatory Surgery Centers (ASC) for all previous deficiencies cited on 9/15/23. All deficiencies have been corrected and no new non-compliance was found. The Endoscopy Center, Inc. was found in compliance with all regulations surveyed.	Q0000		

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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001015	A. BUILDING 01 - MAIN BUILDING 0... B. WING	10/30/2023

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K0000 Bldg. 01	INITIAL COMMENTS A revisit survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/1/23. The Endoscopy Center, Inc was found in compliance with 42 CFR 416.44(b)(1) requirements for Ambulatory Surgical Centers.	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.

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