

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 06/03/2026
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE AESTHETIC SURGERY	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 57105
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(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 6/2/26 through 6/3/26. Rivers Edge Aesthetic Surgery was found not in compliance with the following requirements: Q101 and Q122.	Q0000	Upon identification of the deficient practice on 6/2/2026, the administrator immediately contacted its HVAC contractor to evaluate the ventilation system serving operating rooms 1 and 2. The ventilation system was assessed, balanced and adjusted to restore positive pressure relationships in both operating rooms. Airflow testing was completed following corrective action and verified that positive pressure relationships were maintained in operating rooms 1 and 2.	7/18/2026
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1) The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is NOT MET as evidenced by: Based on observation, airflow testing, interview, policy review, Association of Perioperative Registered Nurses (AORN) review, American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) review, and Administrative Rules of South Dakota review, the provider failed to ensure that two of two operating rooms' (1 and 2) air pressure relationships were maintained in positive (clean) pressure to prevent the spread of infections and ensure the health of the patients was maintained. Findings include: 1. Observation and airflow testing on 6/2/26 at 11:45 a.m. in operating room (OR) 1 revealed, with the use of a vaneometer (device used to monitor the direction of airflow), negative (dirty) air from the corridor (hallway) was blowing into OR 1. The OR's airflow should have been drawn out into the corridor to keep contaminants out.	Q0101	No patients were identified as having experienced adverse outcomes related to the airflow issue. Because the deficient practice affected both operating rooms, all patients receiving procedures in those rooms during the period of concern were considered potentially affected, so all surgeries were delayed until corrective actions had been made on 6/3/2026. The Environmental Temperature, Humidity and Airflow Monitoring Policy was revised to require daily verification and documentation of operating room pressure relationships prior to the start of surgical procedures. A daily Operating Room Environmental Monitoring Log was implemented requiring staff to verify and document operating room temperature, humidity and positive pressure relationships for each operating room prior to the start of surgical procedures on each day the facility is operational. All staff responsible for environmental monitoring were educated regarding operating room pressure requirements, testing procedures (vaneometer and tissue test), documentation requirements, acceptable parameters and notification procedures when airflow parameters are not met. Daily Operating Room Environmental Monitoring Logs will be maintained documenting temperature, humidity and positive pressure status of each operating room. This log will be monitored by the Director of Nursing or designee. The operating room temperature, humidity, and positive pressure relationships will be verified and documented prior to the start of surgical procedures on each operational day. The Director of Nursing will review the completed logs monthly to verify compliance. Daily monitoring will remain a permanent facility practice. The Director of Nursing will summarize the environmental monitoring compliance and any identified variances for review at quarterly Quality Assessment and Performance Improvement (QAPI) and Board of Governors meetings. Findings, corrective actions and trends will be documented and additional corrective actions implemented as necessary.	

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 <i>Jodi Pierret</i>	TITLE <u>Administrator</u>	(X6) DATE <u>6/18/2026</u>
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE AESTHETIC SURGERY	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 57105
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Q0101	<p>Continued from page 1</p> <p>2. Observation and airflow testing on 6/2/26 at 11:55 a.m. in OR 2 revealed that, with the vaneometer, negative air from the corridor was blowing into OR 2. The OR's airflow should have been drawn out into the corridor to keep contaminants out.</p> <p>3. Interview on 6/2/26 at 12:00 p.m. with director of nursing (DON) A revealed she confirmed negative air was blowing into the ORs. She was not aware that the air-pressure relationships in the ORs were incorrect, or how long the pressure was not maintained. It was not part of the staff's daily responsibilities to verify proper airflow. She stated, "We just assumed it was working."</p> <p>4. Review of the provider's 1/14/26 Environmental Temperature & Humidity Monitoring policy revealed that it did not indicate that the staff were to check the air pressure relationships of the ORs within the surgical suite.</p> <p>5. Review of AORN's 2024 Guidelines for Perioperative Practice: Design and Maintenance, pp. 116 and 128 revealed, "Design the OR to have a positive pressure gradient to all surrounding areas. Use a ventilation setback strategy that maintains the positive pressure relationships of the OR to the adjacent area."</p> <p>6. Review of the 2020 addendum ASHRAE Standard 170-2017 Ventilation of Health Care Facilities Design Parameters 7.4.1 revealed the operating room "shall be maintained at a positive pressure with respect to all adjoining spaces at all times."</p> <p>7. Review of the Administrative Rules of South Dakota 44:76:11:19 ventilating systems revealed, "The mechanical ventilation systems shall be designed and balanced to provide make-up air and safe pressure relationships between adjacent areas to preclude the spread of infections and assure the health of the occupant."</p>	Q0101		
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Q0122	<p>REAPPRAISALS</p> <p>CFR(s): 416.45(b)</p> <p>Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on credential file review, medical staff bylaws</p>	Q0122		
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<p>NAME OF PROVIDER OR SUPPLIER RIVERS EDGE AESTHETIC SURGERY</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 57105</p>		
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<p>Q0122</p>	<p>Continued from page 2 review, and interview, the provider failed to ensure credentials and privileges were reviewed and approved for a specific timeframe according to medical staff by-laws for one of one sampled (C) physician assistant (PA). Findings include:</p> <ol style="list-style-type: none"> 1. Review of PA C's credentialing file revealed her initial credentialing review and approval were approved on 4/12/24. An approval letter from the credentials' committee, dated 4/12/24, stated this approval would expire two years from the date of the letter. There was an application and a provider's reference letter dated 6/2/26, but there was no current approval letter. 2. Review of the provider's 12/12/16 Medical Staff and Bylaws revealed that initial appointments shall be for a period of two years. Reappointments shall be for a period of not more than two years. 3. Interview on 6/2/26 with administrator B revealed she was currently working on recredentialing PA C. Medical director D did not approve her recredentialing or delineation of privileges. She thought PA C was due for recredentialing in August and had forgotten PA C started in April. 	<p>Q0122</p>	<p>Upon identification of the deficiency, the practitioner's credentialing file was immediately reviewed. The provider completed the reappointment process and the credentialing department verified that current privileges, licensure, certification, professional liability coverage and competency documentation were current and compliant with the Medical Staff Bylaws. The Medical Director signed off of the active privileges on 6/3/26 and the provider was able to continue treating patients.</p> <p>A comprehensive review of all active medical staff files was conducted to verify that all practitioners were within the required reappointment timeframe. No additional expired reappointments were identified.</p> <p>A Medical Staff credentialing, privileging roster and reappointment tracking log was implemented to include all credentialed practitioners and their reappointment due dates. Electronic calendar reminders have been established at 90 days and 60 days prior to reappointment expiration dates. The Administrator or credentialing supervisor will review the credentialing log monthly and sign off the acknowledgement to identify any upcoming reappointments.</p> <p>This process will monitor reappointment due dates, percentage of practitioners reappointed within the required two-year cycle and the number of practitioners with expired or overdue reappointments.</p> <p>The administrator will complete a monthly review of the credentialing and privileging tracking log with quarterly audit of 100% of active medical staff files to verify compliance with reappointment requirements.</p> <p>Goal is 100% of practitioners will maintain current privileges and be reappointed within the timeframe required by the Medical Staff Bylaws. Any provider identified as approaching expiration without completed reappointment documentation will be addressed immediately by the administrator.</p> <p>Results of monthly monitoring and quarterly audits will be reported by the Administrator to the Quality Assessment and Performance Improvement Committee (QAPI) and Board of Governors (BOG).</p> <p>Monitoring results, identified trends, corrective actions and compliance rates will be documented in QAPI meeting minutes. Ongoing monitoring by the administrator or credentialing staff will be on going on a monthly basis.</p>	<p>7/18/2026</p>

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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE AESTHETIC SURGERY	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 S MINNESOTA AVE SUITE 111 , SIOUX FALLS, South Dakota, 57105
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E0000	<p>Initial Comments</p> <p>A recertification survey for compliance with 42 CFR Part 416, Subpart C, Subsection 416.54, Emergency Preparedness, requirements for ambulatory surgery centers (ASC), was conducted on 6/2/26. Rivers Edge Aesthetic Surgery was found in compliance.</p>	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jodi Pierret</i>	TITLE Administrator	(X6) DATE 6/18/2026
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026
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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted on 6/2/26 for compliance with 42CFR 416.44(b)(1), requirements for ambulatory surgery centers. Rivers Edge Aesthetic Surgery was found in compliance.</p>	K0000		

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 63819	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2026
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE AESTHETIC SURGERY	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 SOUTH MINNESOTA AVE STE 111 SIOUX FALLS, SD 57105
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S 000	<p>Compliance/Noncompliance</p> <p>A licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted from 6/2/26 through 6/3/26. Rivers Edge Aesthetic Surgery was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jodi Pierret* TITLE Administrator (X6) DATE 6/18/2026