STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , 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 was conducted from 2/4/25 through 2/6/25. Black Hills Regional Eye Surgery Center was found not in compliance with the following requirements: Q0060, Q0064, Q0065, Q0109, Q0181, and Q0241.	Q0000		
Q0060	SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC This CONDITION is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to: *Maintain appropriate temperatures and humidity levels in four of four of operating rooms (OR) for three of three months reviewed (November 2024 through January 2025) within acceptable standards of practice. *Perform a proper time-out (verification of patient's name, date of birth, and procedure) prior to a surgical procedure for two of two patients (19, 20). *Ensure a pre-surgical assessment and anesthesia assessment had been documented and the updated history and physical had been signed prior to anesthesia administration for 16 of 20 sampled (2, 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, and 20) patients. Finding include: 1. Observation, record review, interview, and policy review throughout the survey process from 2/4/25 through 2/6/25 revealed:	Q0060	Q0060: Refer to Q0064 finding 1 for complete POC (below). Mechanical adjustments were made to allow for more consistent temp and humidity readings within the appropriate parameters. Staff was educated and an action log was developed for maintenance to use for out of range readings. On-going audits will occur to ensure sustained compliance. Refer to Q0064, finding 2 (below). Staff and physicians will be reeducated of components of a proper surgical time out (already outlined in policy). Audits will be completed to ensure sustained compliance. Refer to Q0065 (below). CRNAs and Physicians will be re-educated on proper timing of completing/documenting the pre-anesthesia assessment and reviewing/signing the H&P document. On-going audits will occur to ensure sustained compliance.	3/18/2025

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
	Administrator	2/28/25

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	43C0001003	A. BUILDING B. WING	02/06/2025

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Q0060	Continued from page 1 *Temperatures and humidity levels in four of four operating rooms had not been between 68 to 73 degrees Fahrenheit (F) and 20 to 60 percent humidity from November 2024-January 2025. *There had been no corrective actions documented when temperature or humidity levels had gone out of the acceptable range. *Staff had been unaware of what the temperature and humidity levels should have been. Refer to Q0064, finding 1. 2. Observations, interviews, and policy review throughout the survey process from 2/4/25 through 2/6/25 revealed a time-out verification process for two of two patients (19 and 20) having a surgical procedure had not been performed according to provider's policy. Refer to Q0064, finding 2. 3. Interviews and record reviews throughout the survey process from 2/4/25 through 2/6/25 revealed history and physicals had been signed and the anesthesia assessment time had occurred after the anesthesia assessment for the above listed surgical patients. Refer to Q0065, finding 1.	Q0060	Q0064, Finding 1, Temp and Humidity: Adjustments were made to the airflow and humidifier during the inspection. All 4 ORs were observed to be within range for both Temp and Humidity by surveyor on 2/6/25. Since then, all OR staff was educated 2/12/2025 on appropriate ranges for both temp and humidity. Appropriate temp and humidity ranges were added to the " Preventative Maintenance" policy and will be reviewed and signed by the Governing Body on 3/10/25. OR staff has also been educated to verify both temp and humidity are WNL upon opening the OR. Any readings found out of range will be communicated immediately to Maintenance for further action. A separate log has been created tor Maintenance to document the date, location, problem, and action taken for any readings out of range. The OR Manager will monitor the current temp and humidity logs with the accompanying maintenance log weekly through March to ensure action is being taken/documented for any readings out of range. Weekly audits will continue if readings are out of range 2 or more days a week. Once weekly audits demonstrate readings within the acceptable range consistently (1 or less operating days/wk), it will then be reviewed quarterly at the Safety Committee meeting. Weekly, then quarterly audits will be reported to QA to ensure sustained compliance.	3/18/2025
Q0064	STANDARD LEVEL TAG FOR SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC. This STANDARD is NOT MET as evidenced by: Based on observation, record review, interview, policy review, and Administrative Rules of South Dakota review, the provider failed to: *Maintain appropriate temperatures and humidity levels in four of four of operating rooms (OR) within acceptable standards of practice of 68 to 73 degrees Fahrenheit (F) and 20 to 60 percent humidity from November 2004 through January 2025. *Perform a proper time-out (verification of patient's	Q0064	Q0064, Finding 2, Time-Out: All staff will be re-educated at ESC staff meeting on 3/13/25 on the components of a proper timeout directly from our policy. Physicians will be re-educated at the Governing Body meeting 3/10/25. Signature's will be obtained to acknowledge understanding. Any staff/physician not in attendance will be re-educated one on one. OR Manager will monitor 20 randomly selected time-outs between now and March 18th to ensure all components are completed correctly. 18 or more out of 20 complete time-outs will demonstrate sustained compliance and will then be audited quarterly. Audits will be reported to QA quarterly to ensure on-going compliance. Staff have been educated to communicate with OR Manager/QA should the need for further education/monitoring seem necessary	

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Q0064	Continued from page 2 name, date of birth, and procedure) prior to a surgical procedure for two of two observed patients (19 and 20). Findings include: 1. Review of the OR's November 2024 temperature and humidity documentation revealed: *OR one had been less than 68° F for 30 of 30 days and less than 20% humidity for 4 of 30 days. *OR two had been less than 68° F for 29 of 30 days and less than 20% humidity for 3 of 30 days. *OR three had been less than 68° F for 30 of 30 days and less than 20% humidity for 3 of 30 days. *OR four had been less than 68° F for 30 of 30 days and less than 20% humidity for 4 of 30 days. Review of the OR's December 2024 temperature and humidity documentation revealed: *OR one had been less than 68° F for 30 of 31 days and less than 20% humidity for 9 of 31 days. *OR two had been less than 68° F for 31 of 31 days and less than 20% humidity for 4 of 31 days. *OR three had been less than 68° F for 31of 31 days and less than 20% humidity for 8 of 31 days. *OR four had been less than 68° F for 25 of 31 days and less than 20% humidity for 11 of 31 days. Review of the OR's January 2025 temperature and humidity documentation revealed: *OR one had been less than 68° F for 26 of 28 days and less than 20% humidity for 19 of 28 days. *OR two had been less than 68° F for 28 of 28 days and less than 20% humidity for 12 of 28 days. *OR three had been less than 68° F for 28 of 28 days and less than 20% humidity for 18 of 28 days. *OR four had been less than 68° F for 22 of 28 days and less than 20% humidity for 20 of 28 days. Interview with central supply technician D on 2/5/25 at 10:40 a.m. revealed she: *Had not been aware of the acceptable standards of	Q0064		

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Q0064	Continued from page 3 practice for temperature and humidity in an OR. *Stated, "I just write down the number from the monitor on the log." *Had not placed a maintenance repair request as she was not aware the temperature or humidity had been out of range. Interview with maintenance manager C on 2/5/25 at 12:30 p.m. confirmed he: *Was unaware the temperature and humidity levels in the surgical eye center ORs had been out of the acceptable ranges. *Had not documented the acceptable ranges for staff to reference. *Agreed the temperature and humidity levels had been out of range for the past three months. *Would contact the contracted service who handled their ventilation system to fix the issue. Interview with director of nursing (DON) A and chief financial officer (CFO) B on 2/5/25 at 12:35 p.m. revealed: *CFO B confirmed of planned ventilation adjustments and new HVAC (heating and cooling) units replacement in March 2025. *DON A confirmed temperature and humidity levels had been checked daily throughout the surgical eye center ORs, but there had been no actions taken when those were out of range. *CFO B and DON A confirmed the provider had no policy defining acceptable standards of practice for temperature and humidity levels in the ORs. Review of the 2020 American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) Standard 170-2017 for operating room indicated the acceptable temperature range is 68-75 degrees F and 20-60% humidity. Review of the 2018 Association for Professional in Infection Control and Epidemiology (APIC) text, 4th edition design standards for operating rooms recommended a temperature range of 68 degrees F to 75 degrees F.	Q0064		

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Q0064	Continued from page 4 Review of Association of Perioperative Registered Nurses (AORN) 2024 Guidelines for Perioperative Practice: Design and Maintenance pg. 103 revealed: *"Operating room temperatures 68°-75° F and relative humidity 20-60%." Review of the Administrative Rules of South Dakota 44:76:11:19 ventilating systems revealed: *"The ventilating systems shall maintain temperatures, minimum air changes of outdoor air an hour, minimum total air changes, and relative humidity as follows: -(1) Operating rooms - 68 to 73 degrees Fahrenheit (20 to 22.8 degrees centigrade), three outdoor, 15 total, and 20 to 60 percent humidity." 2. Observation on 2/4/25 at 1:50 p.m. in OR 1 with surgical technician (ST) F and medical doctor (MD) L revealed: *MD L entered OR 1 and grabbed the patient's written consent form to sign and date. *MD L called for a time-out verification. *MD L stated patient 19's name, date of birth, verification of site, and procedure to be performed. -During the time-out verification process, ST F was scrubbing patient 19's right eye with betadine. -ST F had not stopped all activity and not been engaged during the timeout process. Observation on 2/5/25 at 9:48 a.m. in OR 4 with ST F, registered nurse (RN) E, and MD M revealed: *MD M entered OR 4 and had put on sterile attire. *MD M then sat on a stool next to patient 20 and began the surgical procedure. *There had been no time-out verification conducted prior to the beginning of the procedure involving MD M. Interview on 2/5/25 at 10:10 a.m. with RN E revealed she: *Had performed a time-out verification with ST F when patient 20 had entered the OR. *Confirmed a time-out was not completed with MD M prior	Q0064		

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Q0064	Continued from page 5 to the procedure. *Stated, "The time-out should have been done with the doctor as well." Interview on 2/5/25 at 12:30 p.m. with DON A confirmed staff should have: *Stopped all activity during the time-out with all team members engaged. *Performed a time-out prior to the procedure with the MD in the room as instructed in the provider's policy. Review of provider's 12/2020 Admission through Discharge Routine for the Surgical Patient policy revealed: *"A time-out is conducted immediately prior to beginning a procedure. *The provider performing the procedure assumes responsibility for the time-out and the entire team is engaged in the time-out. *The circulating nurse will identify the patient by checking the ID bracelet, verify the operative eye and intended procedure by reviewing the consent with the anesthesia provider, OR technician, and MD prior to the beginning of the procedure."	Q0064		
Q0065	PHYSICIAN EVALUATION OF RISK CFR(s): 416.42(a)(1)(i) [§416.42(a)(1) Immediately before surgery --] (i) A physician must examine the patient to evaluate the risk of the procedure to be performed; This STANDARD is NOT MET as evidenced by: Based on record review, policy review, and interview, the provider failed to ensure a presurgical assessment and anesthesia assessment had been documented and the updated history and physical (H&P) signed prior to anesthesia administration for 16 of 20 sampled (2, 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, and 20) patients. Findings include: 1. Review of the 17 patient charts listed above revealed: *Patient 2:	Q0065		

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Q0065	Continued from page 6 -Admitted on 1/15/25. -Anesthesia assessment at 11:24 a.m. -Anesthesia administered at 11:04 a.m. -Updated H&P was signed on 1/21/25 at 3:21 p.m. *Patient 3: -Admitted on 1/8/25. -Anesthesia assessment at 11:28 a.m. -Anesthesia administered at 11:14 a.m. -Updated H&P was signed on 1/8/25 at 12:45 p.m. *Patient 4: -Admitted on 12/19/24. -Anesthesia administered at 8:40 a.m. -Updated H&P was signed on 12/30/24 at 3:12 p.m. *Patient 5: -Admitted on 12/10/24. -Anesthesia assessment at 10:29 a.m. -Anesthesia administered at 10:08 a.m. -Updated H&P was signed on 12/10/24at 3:54 p.m. *Patient 6: -Admitted on 12/2/24. -Anesthesia assessment at 1:34 p.m. -Anesthesia administered at 12:55 p.m. -Updated H&P was signed on 12/30/24at 1:36 p.m. *Patient 8: -Admitted on 11/18/24. -Anesthesia assessment at 9:24 a.m. -Anesthesia administered at 9:06 a.m.	Q0065	Q0065, Finding 1, H&P/Anes Assessment: The physicians will be re-educated on the requirement to sign/update H&Ps prior to surgery at their Governing Body meeting on March 10th. The CRNAs assess/evaluate every patient prior to surgery to identify any potential concerns. If concerns are identified, they are communicated to the physician and documented prior to surgery. If no concerns are identified, such is documented in the Pre-Op H&P record, which is then reviewed and signed by the physician. A timestamp has been added to the document to indicate when the H&P was reviewed by the physician (prior to surgery). OR Manager will review 30 charts between March 11th-18th to ensure 85% compliance is being met. This item has been edited/updated in our quarterly nursing chart audits to ensure ongoing compliance quarterly. Any future deficiencies will be reported to OR Manger/QA/Governing Body in the quarterly chart audit report. The CRNAs were verbally educated 2/5/25, and will be re-educated at the staff meeting 3/13/25 to document their pre-anesthesia assessment immediately upon completion of the assessment. Signatures will be obtained to acknowledge understanding. The assessment is currently being done at the appropriate time but is often documented (electronic time stamp) after sedation as they catch up on their charting after they've performed their hands-on tasks. OR Manager will review 10 charts weekly through March 18th to ensure 90% compliance is being met. This will also be added to the quarterly CRNA chart audits to ensure ongoing compliance after the initial monitoring period. Any future deficiencies will be reported to OR Manger/QA/Governing Body in the quarterly CRNA chart audit report.	3/18/25

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Q0065	Continued from page 7 -Updated H&P was signed on 11/20/24 at 4:42 p.m. *Patient 9: -Admitted on 11/8/24. -Anesthesia assessment at 8:48 a.m. -Anesthesia administered at 8:05 a.m. -Updated H&P was signed on 11/27/24 at 1:46 p.m. *Patient 12: -Admitted on 10/11/24. -Anesthesia assessment at 10:48 a.m. -Anesthesia administered at 9:57 a.m. -Updated H&P was signed on 10/11/24 at 2:21 p.m. *Patient 13: -Admitted on 10/11/24. -Anesthesia assessment at 7:50 a.m. -Anesthesia administered at 7:12 a.m. -Updated H&P was signed on 10/11/24 at 2:54 p.m. *Patient 14: -Admitted on 9/18/24. -Anesthesia assessment at 12:51 p.m. -Anesthesia administered at 12:28 p.m. -Updated H&P was signed on 9/18/24 at 3:47 p.m. *Patient 15: -Admitted on 9/3/24. -Anesthesia assessment at 9:25 a.m. -Anesthesia administered at 9:25 a.m. -Updated H&P was signed on 9/10/24 at 9:33 a.m. *Patient 16:	Q0065		

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Q0065	Continued from page 8 -Admitted on 8/23/24. -Anesthesia assessment at 2;46 p.m. -Anesthesia administered at 2:30 p.m. -Updated H&P was signed on 8/26/24 at 9:01 a.m. *Patient 17: -Admitted on 8/14/24. -Anesthesia assessment at 11:23 a.m. -Anesthesia administered at 11:18 a.m. -Updated H&P was signed on 8/14/24 at 1:32 p.m. *Patient 18: -Admitted on 8/5/24. -Anesthesia assessment at 1:41 p.m. -Anesthesia administered at 1:38 a.m. -Updated H&P was signed on 8/15/24 at 12:11 p.m. *Patient 19: -Admitted on 2/4/24. -Anesthesia assessment at 1:32 p.m. -Anesthesia administered at 1:23 a.m. -Updated H&P was signed on 2/4/24 at 7:45 p.m. *Patient 20: -Admitted on 2/5/24. -Anesthesia administered at 9:22 a.m. -Updated H&P was not signed. Review of the provider's 8/17/22 Anesthesia Services policy revealed "a physician or Certified Registered Nurse Anesthetist (CRNA) must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed." Interview on 2/4/25 at 4:15 p.m. with chief financial officer B revealed the surgeons would sign the	Q0065		

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Q0065	Continued from page 9 patient's history and physical and the operatory report at the same time after the surgical procedure. Interview on 2/5/25 at 3:30 p.m. with Director of Nursing A revealed: *The surgeons would not have signed the pre-surgical assessment/updated H&P until after the surgery had been performed. *Prior to switching to the new electronic system the surgeons had signed the updated H&Ps prior to surgery. *The timing of the anesthesia assessment by the certified nurse anesthetists in the patient chart looked like the assessment occurred after the anesthesia had been administered.	Q0065		
Q0109	EMERGENCY EQUIPMENT CFR(s): 416.44(d) (d) Standard: Emergency equipment. The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. This STANDARD is NOT MET as evidenced by: Based on observation, interview, policy review, and manufacturer's instructions for use (IFU) review, the provider failed to ensure: *One of one Lifepak (defibrillator) 20e had been checked daily per manufacturer's IFU. *One of one crash cart had been checked daily when the eye surgery center was open per policy. Findings include:	Q0109	Q0109, Crash Cart Daily Checks: Re-educated staff member responsible for daily checks of importance/requirement of completing this daily when the facility is open on 2/5/25. Staff member has changed process to complete this right away in the morning before starting any task to avoid forgetting later in the day. The on-call nurses have been educated verbally on 2/24/25 on being newly assigned as the back-up for days the usual staff member responsible for this is not working. A follow-up statement of these requirements/expectations was printed and in the process of being signed/acknowledged by all on-call nursing staff. We will again review this at our staff meeting on 3/13/25 to ensure there are no further questions. Lastly, the daily checklist has been updated to include all required components of the daily test per MFU (had been updated and reviewed by surveyor on 2/5/25 prior to completion of survey). OR manager will monitor/audit the daily checklist weekly through the 2nd quarter (June 2025) for sustained compliance of 90% or greater. Ongoing audits will continue quarterly with compliance below 90% until consistently meeting or exceeding this goal. Audits will be reported to QA quarterly until compliance is achieved.	3/13/25

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Q0109	Continued from page 10 1. Observation and interview on 2/4/25 at 3:10 p.m. in the preop/recovery care unit with director of nursing (DON) A revealed: *Lifepak 20e defibrillator and crash cart had not been checked on 1/29/25, 1/30/25, 1/31/25, 2/3/25, and 2/4/25. *She confirmed the crash cart, and defibrillator should have been checked daily when the eye surgery center was open and taking care of patients. *She stated, " There is only one person that checks the defibrillator and crash cart, and she has been off." *She confirmed there had not been a back-up person assigned to check the crash cart and defibrillator. *She confirmed the defibrillator and crash cart had not been checked for five days. *The provider's daily crash cart checklist instructed staff to verify if the Lifepak 20e self-test had printed daily and to initial the printed slip. *She confirmed staff had not performed the steps according to the manufacturer's IFU when checking the Lifepak 20e. Review of the provider's 3/19/24 Emergency Medical Equipment & Supplies policy revealed: *"Each emergency cart has an inventory list of supplies, medication, and expiration dates. *Each emergency care is inspected monthly based on the accompanying logs. *Crash cart functions are tested and logged daily." Review of the provider's Daily Crash Cart Checklist revealed a section to document the Lifepak 20e self-test prints daily at 3:00pm. Review of the manufacture's 2019 IFU for the Lifepak 20e Defibrillator/Monitor Operator's Checklist revealed: *"1. Check printed result of 3 A.M. daily auto test. *2. Inspect physical condition for: -Foreign substances.	Q0109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , RAPID CITY, South Dakota, 57701

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Q0109	Continued from page 11 -Damages or cracks. *3. Inspect power source *4.Check therapy and ECG electrodes for: -Use by date. -Spare electrodes available. *5. Examine accessory cables for: -Cracking, damage, broken or bent parts or pins, and paddle surfaces for pitting. *6. Disconnect the defibrillator from AC power, wait 2 seconds, press ON and check for: -Momentary SELF-TEST messages, illumination of LEDs, and speaker beep. -Services LED is lit. *7. Check ECG printer for: -Adequate paper supply. -Ability to print. *8. Confirm therapy cable connected to defibrillator to perform cable check: -If QUIK-COMBO therapy cable is connected: --Confirm test plug connected to therapy cable. --Press ANALYZE button. --After ANALYZING NOW message, look for REMOVE TEST PLUG message. *9. Reconnect to AC power and then power off the device."	Q0109		
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:	Q0181		

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Q0181	Continued from page 12 Based on observation, interview, and manufacturer's instruction for use (IFU) review, the provider failed to ensure multiple bottles of opened proparacaine hydrochloride ophthalmic solution 0.5% (numbing medication) eye drops had been stored correctly. Findings Include: 1. Observation of licensed practical nurse (LPN) H on 2/4/25 at 1:15 p.m. with patient 19 in the preop/recovery care unit revealed: *She grabbed a proparacaine eye drop bottle from a basket located on a computer station. *She administered two drops of proparacaine eye drops into patient's 19 right eye. *She placed the proparacaine bottle back into a basket and handed the eye drops off to another nurse. *After each use observed for multiple patients, the proparacaine eye drops had been placed back into a basket on a bedside stand. Interview on 2/4/25 at 1:35 p.m. with LPN H revealed proparacaine eye drops: *Had not been stored in their original carton. *Had not been refrigerated after use. *Were removed from the refrigerator prior to opening but had not been placed back in the refrigerator after they were opened. Observation and interview on 2/4/25 at 2: 35 p.m. with director of nursing (DON) A in the preop/recovery care unit revealed: *Multiple opened bottles of proparacaine hydrochloride ophthalmic solution 0.5% eye drops had been stored in a basket in a locked cabinet. *She confirmed the proparacaine eye drops bottles had not been stored in the original carton or in a refrigerator after they were opened. Review of the manufacturer's 9/2022 IFU of Proparacaine Hydrochloride Ophthalmic Solution 0.5% revealed: *"Storage: -Bottle must be stored in unit carton to protect	Q0181	Q0181, Proparacaine: Working with our consulting pharmacist on getting necessary documentation from our Proparacaine manufacturer to support research studies available indicating efficacy at room temperature for 2 weeks. If able to obtain, will update policy to reflect a 2-week expiration of Proparacaine, which will be labeled appropriately upon opening with the date opened and date of expiration. OR Manager will ensure the Medication Policy is updated to reflect guidelines provided by Proparacaine manufacturer. Policy updates will be reviewed and signed by Governing Body during 3/10/25 meeting. Infection Control will conduct weekly audits of this process for 4 weeks to ensure appropriate labeling and discarding after 2- weeks is occurring. From there, quarterly audits will occur and be reported to QA to ensure on-going compliance is met. **Should this documentation not be made available, the physicians will switch to using Tetracaine 0.5% drops which does not require refrigeration. OR Manager will ensure that Tetracaine 0.5% is ordered by our Ordering RN to replace Proparacaine, that our formulary is updated to reflect necessary changes, and any pre-existing orders for Proparacaine will also be amended for Tetracaine. OR Manager will implement the change by March 13th so education and receipt of education can be obtained during our ESC Staff Meeting on 3/13/25. Any nursing staff not present at 3/13 meeting will be educated one on one by OR Manager the following working day. Signatures will be obtained by all staff of understanding of new process.	3/14/25

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Q0181	Continued from page 13 contents from light. -Store bottles under refrigeration at 2°C (Celsius) to 8°C (36°F (Fahrenheit) to 46°F)." The provider did not have a policy regarding proper storage of proparacaine eye drops.	Q0181	Q0241: Transporting Dirty Instruments: Techs are the only staff who transport dirty instruments to decontam. Techs were verbally re-educated on 2/10/25 to always return instruments to hard cases with secure lids prior to transporting contaminated instruments to sterile processing. This was already in place for all surgeries aside from retina and oculoplastic. Our policy did state that "hand carried items could be covered with an instrument wrap" vs secured in a leak-proof, puncture-resistant container. The Surgical Instrument Cleaning and Care policy has been updated to reflect the following: "Contaminated instruments must be transported to the decontamination area in a closed container or enclosed transport cart that is leak proof, puncture resistant, large enough to contain all contents, and labeled with a red label containing "Biohazard". Additionally, more detail was added to "Liquids must be contained in a spill-proof container" to include the updated process. Any sterile water will be suctioned into the leak-proof" suction canister at the end of the case. This will be labeled "Biohazard" and placed in a red bag prior to transport to soiled waste. This policy will be reviewed and signed by the Governing Body on 3/10/25. Upon approval of this policy, all ESC staff will be educated of this at our staff meeting on 3/13/25. Signature's will be obtained as receipt and acknowledgment of updated policy. Any staff who are not present will be educated the following working day by OR manager who will obtain receipt of acknowledgement by signature. OR Manager has requested a Biohazard sticker to be placed in our sterile packs to accompany our current medication labels. The pack company has approved this change and has indicated we will see this update in our packs in 4-6 weeks. For now, the techs will write " Biohazard" on the blank sticker until the official Biohazard labels arrive in the pack. The techs were verbally educated to label their dirty instruments with this Biohazard sticker prior to transport to sterile processing on 2/10/25. (Continued below-)	
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: *Expired supplies had been removed from three of three anesthesia carts and were available for patient use. *Two of two basins holding contaminated instruments containing blood and bodily fluids had been transported in a sealed container and were labeled as biohazardous. Findings include: Observation and interview on 2/5/25 at 10:10 a.m. with surgical technical F in operating room (OR) 4 revealed she: *Placed four surgical instruments containing blood and bodily fluids in a round basin filled with sterile water. *Proceeded to wrap the basin with her used surgical gown. *Transported the basin wrapped in her surgical gown to the decontamination area. -This basin was not sealed, puncture resistant, or leak proof. -The surgical gown was not puncture resistant, leak proof, or labeled as biohazardous. *She confirmed: -Instruments may be transported in water.	Q0241		3/14/25

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Q0241	Continued from page 14 -Instruments were placed in a round basin either in their protective cases or placed directly in the basin filled with sterile water. -The surgical gown had not been labeled as biohazardous. Interview on 2/5/25 at 10:15 a.m. with central supply technician J revealed: *Contaminated instruments had been transported in a round basin covered with a surgical gown. *Instruments were transported in sterile water. *The round basin containing contaminated instruments were not labeled as biohazardous. *She confirmed: -Not all the containers staff used for transporting used surgical instruments had lids. -A biohazardous label had not been used on the surgical gown. -Instruments were dirty because they had been wrapped in a surgical gown. *The surveyor's observation of transporting used surgical instrument was their usual process. -That process did not ensure safety related to puncture resistant, leak-proof containers, and labeling of biohazardous items. 2. Observation on 2/4/25 at 2:30 p.m. in the preop/recovery care unit in an anesthesia cart revealed one pack of sterile gloves had expired on 3/31/24. Observation on 2/5/25 at 11:00 a.m. outside OR 1 of two of two anesthesia carts revealed: *Size 7 Shiley endotracheal tube (ETT) (breathing tube) expired on 7/9/24. *Size 6.5 Shiley ETT expired on 9/25/22. *Size 8 Shiley ETT expired on 6/24/24. *Two nasopharyngeal (nose) airway devices expired on 1/28/24.	Q0241	Q0241 (Cont.): 20 cases will randomly be audited by Infection Control to observe the dirty instruments from the OR to sterile processing to ensure all have been placed back into their hard cases with secure lids and labeled with the Biohazard sticker prior to transport. If sterile water was used, observation will include ensuring sterile water is suctioned into the leak-proof suction canister, labeled, and disposed of properly. Observation will begin 3/3/25 and will be completed by 3/14/25. Ongoing weekly audits will continue as needed until 90% compliance is achieved. Initial and any necessary weekly audit results will be reported to QA. Quarterly audits will be performed by Infection Control and reported to QA. Infection Control nurse will add these items to the Annual Infection Control training for annual review by all staff and physicians. Q0241, Expired Supplies Anes Carts: CRNAs were verbally re-educated on 2/6/25 to check other supplies in the carts monthly, in addition to their medications. Their monthly cart checklist has been updated to reflect both supplies and medications. OR manager will monitor the monthly checklists/carts through April to ensure compliance (presence of 2 or less expired items) is being met. On-going bi-annual audits will be performed by OR manager for QA reporting to ensure sustained compliance	

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Q0241	Continued from page 15 *Double stick disks (adhesive tape) expired on 7/2/22. *Oral tracheal tube expired on 4/1/24. *Size 5 adult single use laryngeal mask expired on 8/29/24. *Size 3 adult single use laryngeal mask expired on 7/20/24. *Size 2 pediatric single use laryngeal mask expired on 7/13/24. Interview on 2/5/25 at 11:10 a.m. with certified registered nurse anesthetist (CRNA) I confirmed supplies were expired and he would remove the supplies from the carts and replace. Review of the provider's 5/2021 Equipment and Supplies policy had not addressed management of expired supplies. 3.Interview on 2/5/25 at 12:30 p.m. with director of nursing (DON) A revealed: *The provider followed the Association of Perioperative Registered Nurses (AORN) guidelines to guide their practice and write policies. *Staff should not have been transporting instruments in water. *Staff should have placed the contaminated instruments back in the rigid cases they were stored in. *Instruments had not been labeled as biohazardous and had been unaware they needed to be. *She confirmed staff knew the instruments were dirty because they had been covered with a surgical gown. *Confirmed anesthesia staff are responsible for checking outdates in their carts and expired items should have been removed. Interview on 2/5/25 at 4:30 p.m. with infection prevention registered nurse G revealed: *The provider followed Center for Disease Control (CDC), AORN, and Association for Professional in Infection Control and Epidemiology (APIC) national guidelines to guide their practice and write policies.	Q0241		

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Q0241	Continued from page 16 *She confirmed: -Contaminated instruments had been placed in a basin and wrapped in a surgical gown. -Staff transported contaminated instruments in a round basin containing sterile water. -Not all contaminated instruments had been placed back into their rigid containers. -The surgical gown covering the basin with contaminated instruments had not been labeled as biohazardous. -Expired supplies should have been removed from anesthesia carts. Observation and interview on 2/6/25 at 10:40 a.m. outside of OR 2 with certified ophthalmic assistant technician K revealed: *Contaminated instruments had been placed in two rigid, puncture resistant containers and placed in a round basin for transport to decontamination. *The basin was covered with a surgical gown. *The surgical gown was not labeled as biohazardous. *She confirmed: -Occasionally instruments had been transported in water. -"We probably aren't supposed to do that." -The surgical gown covering the contaminated instruments had not been labeled as biohazardous. The provider did not have a policy regarding managing outdated or expired supplies. Review of the provider's 5/2021 Surgical Instrument Cleaning and Care policy revealed: *"OSHA prohibits processes that require employees to place their hands into basins of sharp instruments submerged in water because of the risk of percutaneous exposure to bloodborne pathogens. *Re-usable sharps must be placed in a puncture-proof container for transport. *7a. If items are soaked in water or an instrument	Q0241		

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Q0241	Continued from page 17 cleaning solution at the point of use, the liquid should be contained or discarded before transport. This makes transportation easier and less likely to result in injury to personnel. *F. Contaminated instruments must be contained during transport. *OSHA requires that contaminated instruments be contained in a leak-proof container to minimize the risk of exposing personnel to contaminates during transport. -a. hand-carried items must be contained. -b. large quantities of items may be contained within a larger transport container. -d. items with sharp or pointed edges must be contained in a puncture-resistant container. -e. liquids must be contained in spill-proof container." Review of the provider's 5/2021 Cleaning Practices in the Eye Surgery Center policy revealed: *"5. Reusable items contaminated with blood and/or tissue that would release blood or other infectious materials in a liquid or semi-liquid state if compressed, or items that are caked with dried blood or other potentially infectious materials, must be placed in a closable, leak-proof containers, and labeled as infectious." Review of AORN's 2024 Guidelines for Perioperative Practice: Transport to the Decontamination Area pg. 415 revealed: *"7.2. Contaminated instruments must be transported to the decontamination area in a closed container or enclosed transport cart that is: -leak proof, -puncture resistant, -large enough to contain all contents, and -labeled with a fluorescent orange or orange-red label contained a biohazard legend."	Q0241		

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	43C0001003	A. BUILDING B. WING	02/04/2025

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E0000	Initial Comments A recertification survey for compliance with 42CFR 416.44(b)(1), Emergency Preparedness, requirements for ambulatory surgery centers on 2/4/25. Black Hills Regional Eye Surgery Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery centers occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's 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 this section, utilizing an all-hazards approach.	E0004	E0004 Emergency Plan: All staff and physician's review and acknowledge the Emergency Preparedness/Plans with our annual policy review. The Compliance Committee reviews the policies every 2 years to ensure most up to date protocols are in place. Our Emergency Preparedness Policy and accompanying policies were last reviewed on 7/23 within the 2-year timeframe (not 3/22) and was indicated on the policy footer with the previously reviewed dates. Because no revisions had been made to the policy(ies) at that time, it was not signed by a physician but was rather noted of the review date of 7/23. The Governing Body typically only signs if there has been an update or revision to the current policy. If necessary, we have documentation to support that the members of the Governing Body had each reviewed and acknowledged this policy in the last 2 years with our annual policy review. Moving forward, the Governing Body will sign the policy every 2 years, regardless of updates or changes. " Emergency Preparedness update " has been added separately to our Compliance Calendar. The Administrator will ensure this occurs during the Governing Body/Clinical Committee Meeting for that assigned month, and the Compliance Commitee will then verify its completion at the following quarterly meeting.	3/14/25

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
	Administrator	2/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001003	A. BUILDING B. WING	02/04/2025

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E0004	Continued from page 1 * [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 update the emergency preparedness plan agreements (emergency , evacuation transfer) annually. Record review on 2/4/25 at 3:15 p.m. revealed no documentation the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the evacuation plan dated 3/16/22 had no documentation they had been updated annually since that date.	E0004		

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	43C0001003	A. BUILDING 01 - MAIN BUILDING 0... B. WING	02/04/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted for compliance with 42CFR 416.44(b)(1), requirements for ambulatory surgery centers on 2/4/25. Black Hills Regional Eye Surgery Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery centers occupancies upon correction of the deficiencies identified at K342, K353, K355, K915, and K919 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0342	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 feet travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to maintain the fire alarm system as required (missing ceiling tile in the second floor electrical room by the Lasik area). 1. Observation on 2/4/25 at 2:30 p.m. revealed the electrical room on the second floor by the Lasik area had approximately six square feet of tile missing from the overhead lay-in ceiling. The room was equipped with a smoke detector mounted on the underside of some remaining tiles. Interview with the maintenance supervisor at the time of the review confirmed that finding. He stated some conduit work had been done above the lay-in ceiling that accounted for the missing portion of the ceiling. The partial ceiling would interfere with the room's	K0342	K0342 Ceiling Tiles: Maintenance has scheduled the completion of replacing the ceiling tiles with the appropriate party. Estimated completion date given by the company is 3/7/25. Maintenance will report its completion to OR manager who will confirm the work is complete. Maintenance will monitor and assess areas after future repairs to ensure work is complete/compliant and not left unfinished.	3/7/2025

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
	Administrator	2/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , 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
K0342	Continued from page 1 smoke detector's effectiveness.	K0342		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in continuously reliable operating condition (quarterly flow testing not done in 2023 or 2024). 1. Record review at 2:30 p.m. on 2/4/25 at 1:45 p.m. revealed no documentation the required quarterly flow tests had been performed in the past year. Annual fire sprinkler inspections had been performed on 2/29/24 and 12/20/23. Interview with the maintenance supervisor at the time of the record review confirmed that condition.	K0353	K0353 Quarterly Flow Test: Hydraulics Solutions Fire Protection completed the flow test with our annual fire inspection on 2/20/25. This will be done quarterly from here on and has been added to the maintenance checklist. Maintenance will be responsible for obtaining this documentation quarterly. Safety Officer will review reports with Maintenance at the quarterly Safety Committee Meeting for the 2nd and 3rd quarters of 2025 to ensure compliance is met.	Upon approval of this plan
K0355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10,	K0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , 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
K0355	Continued from page 2 Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain fire extinguishers in reliable operating condition (monthly inspection sign-offs). 1. Observation on 2/6/25 at 2:00 p.m. revealed the fire extinguisher in the housing of the generator had an inspection tag with an annual installation date of February 2024. The required monthly inspection information on the back of the tag was blank, indicating no monthly checks had been performed.	K0355	K0355 Portable Fire Extinguishers: Summit Fire Protection serviced/recharged all fire extinguishers 2/6/25. Re-educated Maintenance of monthly inspection requirements. This item is already on the monthly maintenance schedule and had been signed off each month in 2024. Maintenance now understands to physically initial each extinguisher tag once completed for the month and OR Manager will check extinguisher tags monthly through May 2025 to ensure it's being documented properly.	Upon approval of this plan
K0915	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 the generator battery conductivity value monthly (no documentation for calendar year 2024). 1. Record review on 2/4/25 at 1:15 p.m. revealed there was no documentation of the battery conductivity in the	K0915	K0915 Battery Conductivity: Re-occurring monthly service has been set up with Cummins Inc for generator battery inspection and testing. First service has been completed on 2/20/25. Monthly service will include: a) technician will complete visual check of electrical system and start batteries, b) connect a battery conductance tester to the start battery terminals to complete a physical testing of the start batteries, c) adjust start battery charger, if needed, d) provide a written report. Maintenance has set up future service dates and will ensure reports are obtained after each visit. Safety Officer will review reports with Maintenance at the quarterly Safety Committee Meeting for the 2nd and 3rd quarters of 2025 to ensure compliance is met.	Upon approval of this plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , 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
K0915	Continued from page 3 monthly maintenance logs for the generator for the calendar year 2024. Interview with the maintenance supervisor at that same time revealed the monthly battery conductivity had not been documented.	K0915		
K0919 Bldg. 01	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section, any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain the required clearance for two electrical room locations (basement boiler room and second floor by the Lasik area). 1. Observation on 2/4/25 at 1:30 p.m. revealed the electrical room in the basement had a janitor's cart, mop, and boxes of gloves kept in front of the electrical panels. Further observation at 2:30 p.m. revealed the electrical room on the second floor by Lasik had cardboard boxes, a chair, and a metal cart with ceiling grid components kept in front of the electrical panels. The floor should be marked to provide 36 inches of clearance at each location. Interview with the maintenance supervisor at the time of the observations confirmed those findings.	K0919	K0919 Electrical Rooms: Maintenance has been re-educated on the required clearance for both electrical rooms. Maintenance has cleared items from both rooms. Maintenance will check these areas for appropriate clearance monthly and has been added to the monthly maintenance walk-through schedule. Safety Officer will review maintenance walk-through records for first and second quarter of 2025 during the quarterly Safety Committee meeting to ensure compliance is being met.	Upon approval of this plan

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
	11143 S	A. BUILDING: _____ B. WING _____	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD ST RAPID CITY, SD 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) COMPLETE DATE
S 000	Compliance/Noncompliance A licensure survey for compliance with the Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical centers, was conducted from 2/4/25 through 2/6/25. Black Hills Regional Eye Surgery Center was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 2/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS A recertification survey was conducted for compliance with 42CFR 416.44(b)(1), requirements for ambulatory surgery centers on 2/4/25. Black Hills Regional Eye Surgery Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery centers occupancies upon correction of the deficiencies identified at K342, K353, K355, K915, and K919 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0342	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 feet travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to maintain the fire alarm system as required (missing ceiling tile in the second floor electrical room by the Lasik area). 1. Observation on 2/4/25 at 2:30 p.m. revealed the electrical room on the second floor by the Lasik area had approximately six square feet of tile missing from the overhead lay-in ceiling. The room was equipped with a smoke detector mounted on the underside of some remaining tiles. Interview with the maintenance supervisor at the time of the review confirmed that finding. He stated some conduit work had been done above the lay-in ceiling that accounted for the missing portion of the ceiling. The partial ceiling would interfere with the room's	K0342	K0342 Ceiling Tiles: Maintenance has scheduled the completion of replacing the ceiling tiles with the appropriate party. Estimated completion date given by the company is 3/7/25. Maintenance will report its completion to OR manager who will confirm the work is complete. Maintenance will monitor and assess areas after future repairs to ensure work is complete/compliant and not left unfinished.	3/7/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

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K0342	Continued from page 1 smoke detector's effectiveness.	K0342		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in continuously reliable operating condition (quarterly flow testing not done in 2023 or 2024). 1. Record review at 2:30 p.m. on 2/4/25 at 1:45 p.m. revealed no documentation the required quarterly flow tests had been performed in the past year. Annual fire sprinkler inspections had been performed on 2/29/24 and 12/20/23. Interview with the maintenance supervisor at the time of the record review confirmed that condition.	K0353	K0353 Quarterly Flow Test: Hydraulics Solutions Fire Protection completed the flow test with our annual fire inspection on 2/20/25. This will be done quarterly from here on and has been added to the maintenance checklist. Maintenance will be responsible for obtaining this documentation quarterly. Safety Officer will review reports with Maintenance at the quarterly Safety Committee Meeting for the 2nd and 3rd quarters of 2025 to ensure compliance is met.	Upon approval of this plan
K0355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10,	K0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

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K0355	Continued from page 2 Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain fire extinguishers in reliable operating condition (monthly inspection sign-offs). 1. Observation on 2/6/25 at 2:00 p.m. revealed the fire extinguisher in the housing of the generator had an inspection tag with an annual installation date of February 2024. The required monthly inspection information on the back of the tag was blank, indicating no monthly checks had been performed.	K0355	K0355 Portable Fire Extinguishers: Summit Fire Protection serviced/recharged all fire extinguishers 2/6/25. Re-educated Maintenance of monthly inspection requirements. This item is already on the monthly maintenance schedule and had been signed off each month in 2024. Maintenance now understands to physically initial each extinguisher tag once completed for the month and OR Manager will check extinguisher tags monthly through May 2025 to ensure it's being documented properly.	Upon approval of this plan
K0915	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 the generator battery conductivity value monthly (no documentation for calendar year 2024). 1. Record review on 2/4/25 at 1:15 p.m. revealed there was no documentation of the battery conductivity in the	K0915	K0915 Battery Conductivity: Re-occurring monthly service has been set up with Cummins Inc for generator battery inspection and testing. First service has been completed on 2/20/25. Monthly service will include: a) technician will complete visual check of electrical system and start batteries, b) connect a battery conductance tester to the start battery terminals to complete a physical testing of the start batteries, c) adjust start battery charger, if needed, d) provide a written report. Maintenance has set up future service dates and will ensure reports are obtained after each visit. Safety Officer will review reports with Maintenance at the quarterly Safety Committee Meeting for the 2nd and 3rd quarters of 2025 to ensure compliance is met.	Upon approval of this plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLACK HILLS REGIONAL EYE SURGERY CENTER	2800 THIRD STREET , 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
K0915	Continued from page 3 monthly maintenance logs for the generator for the calendar year 2024. Interview with the maintenance supervisor at that same time revealed the monthly battery conductivity had not been documented.	K0915		
K0919 Bldg. 01	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section, any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain the required clearance for two electrical room locations (basement boiler room and second floor by the Lasik area). 1. Observation on 2/4/25 at 1:30 p.m. revealed the electrical room in the basement had a janitor's cart, mop, and boxes of gloves kept in front of the electrical panels. Further observation at 2:30 p.m. revealed the electrical room on the second floor by Lasik had cardboard boxes, a chair, and a metal cart with ceiling grid components kept in front of the electrical panels. The floor should be marked to provide 36 inches of clearance at each location. Interview with the maintenance supervisor at the time of the observations confirmed those findings.	K0919	K0919 Electrical Rooms: Maintenance has been re-educated on the required clearance for both electrical rooms. Maintenance has cleared items from both rooms. Maintenance will check these areas for appropriate clearance monthly and has been added to the monthly maintenance walk-through schedule. Safety Officer will review maintenance walk-through records for first and second quarter of 2025 during the quarterly Safety Committee meeting to ensure compliance is being met.	Upon approval of this plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

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E0000	Initial Comments A recertification survey for compliance with 42CFR 416.44(b)(1), Emergency Preparedness, requirements for ambulatory surgery centers on 2/4/25. Black Hills Regional Eye Surgery Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery centers occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E0000	E0004 Emergency Plan: All staff and physician's review and acknowledge the Emergency Preparedness/Plans with our annual policy review. The Compliance Committee reviews the policies every 2 years to ensure most up to date protocols are in place. Our Emergency Preparedness Policy and accompanying policies were last reviewed on 7/23 within the 2-year timeframe (not 3/22) and was indicated on the policy footer with the previously reviewed dates. Because no revisions had been made to the policy(ies) at that time, it was not signed by a physician but was rather noted of the review date of 7/23. The Governing Body typically only signs if there has been an update or revision to the current policy. If necessary, we have documentation to support that the members of the Governing Body had each reviewed and acknowledged this policy in the last 2 years with our annual policy review. Moving forward, the Governing Body will sign the policy every 2 years, regardless of updates or changes. " Emergency Preparedness update " has been added separately to our Compliance Calendar. The Administrator will ensure this occurs during the Governing Body/Clinical Committee Meeting for that assigned month, and the Compliance Commitee will then verify its completion at the following quarterly meeting.	Upon approval of this plan
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 this section, utilizing an all-hazards approach.	E0004		

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
	Administrator	2/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001003	A. BUILDING B. WING	02/04/2025

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E0004	Continued from page 1 * [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 update the emergency preparedness plan agreements (emergency , evacuation transfer) annually. Record review on 2/4/25 at 3:15 p.m. revealed no documentation the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the evacuation plan dated 3/16/22 had no documentation they had been updated annually since that date.	E0004		