STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001021	A. BUILDING 01 - BROOKINGS AMBUL... B. WING	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKINGS AMBULATORY SURGERY CENTER, LLP	3405 6TH ST , BROOKINGS, South Dakota, 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing ambulatory surgical center) was conducted on 7/8/25. Brookings Ambulatory Surgery Center, LLP was found not in compliance with 42 CFR 416.44 (b)(1) requirements for ambulatory surgery center facilities. The building will meet the requirements of the 2012 LSC for existing ambulatory surgery center occupancies upon correction of deficiencies identified at K131, K291, K918 and K924 in conjunction with the providers 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.	K0131		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael J Hurley	Administrator	08/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BROOKINGS AMBUL... B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

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K0131	Continued from page 1 * 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. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This STANDARD is NOT MET as evidenced by: Based on observation. testing and interview, the provider failed to maintain the fire-resistive design of one of one building separation walls (one-hour wall separating the ambulatory surgical center (ASC) and the clinic). Findings include: 1. Observation, testing, and interview on 7/8/25 at 12:28 p.m. revealed the doors to both the men's and the women's restrooms were found to be ajar. Testing of those doors at that same time revealed they did not close and latch into their frames under the power of the automatic door closers. Further observation revealed those doors to be fire-rated doors located in the 1-hour fire-rated separation from the adjoining clinic. Interview with the maintenance supervisor at that time confirmed those findings. He confirmed those doors were part of the 1-hour fire-rated separation wall. He further stated the ASC had recently been experiencing pressure issues and that was likely causing those doors to remain ajar. Doors in fire-rated wall assemblies are required to automatically close and latch to maintain the fire rating of the wall. The deficiency could affect 100% of the occupants of the smoke compartment.	K0131	Maintenance Supervisor and Administrator adjusted door closers on men's and women's bathroom doors on 07/30/2025. Administrator will check doors monthly to make sure they continue operating correctly through 12/31/2025. The results of the monthly testing will be documented in the 3rd and 4th Quarter CQI reports.	07/30/25
K0291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9	K0291		

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K0291	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on testing, observation, and interview, the provider failed to maintain operational battery pack emergency lighting for two random locations (Electrical/Boiler Room, outdoor generator enclosure). Findings include: 1. Observation and testing at 11:48 a.m. on 7/8/25 revealed the battery backup emergency light for the outdoor generator enclosure was not functioning when tested using the built-in testing button. That battery backup emergency light is required to provide illumination for the generator if it fails to start during a power outage. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Further interview at that same time revealed he was unaware of the testing requirements for that emergency light as part of his preventative maintenance. 2. Observation and testing at 12:41 p.m. on 7/8/25 revealed the battery backup emergency light for the electrical room was not functioning when tested using the built-in testing button. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Further interview at that same time revealed he was unaware of the testing requirements for that emergency light as part of his preventative maintenance. That battery backup emergency light is required to provide illumination for the generator's automatic transfer switch if it fails to start during a power outage.	K0291	Local electrical contractor replaced batteries in emergency lights on 7/30/2025 and they still did not work properly. Electrical contractor checking to see if parts are available to repair the emergency light. If not repairable, emergency lights will be replaced prior to 8/22/2025. Testing the emergency lights has been added to the Maintenance Supervisor's monthly checklist. The Administrator will review the completed monthly checklists for July August and September to determine continued compliance. Director of Nursing will include record of compliance in 3rd Quarter CQI report.	08/22/25
K0918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K0918		

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K0918	Continued from page 3 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the provider failed to maintain (test) the generator battery monthly as required. Findings include: 1. Observation and record review at 10:58 a.m. on 7/8/25 revealed the facility did not have records for the required monthly testing and recording of electrolyte specific gravity or conductance results (Reserve Capacity, "RC") of the lead acid battery for the backup generator. Interview with the maintenance supervisor at that same time confirmed that finding. He further stated he was unaware of the testing requirements for the battery of the backup generator.	K0918	Maintenance Supervisor purchased a battery tester to check the generator battery. Maintenance Supervisor tested the battery on 7/30/2025 and it was fully charged. Checking the generator battery has been added to the Maintenance Supervisor's monthly checklist. The Administrator will review the completed monthly checklists for July August and September to determine continued compliance. Director of Nursing will include record of compliance in 3rd Quarter CQI report.	07/30/25
K0924 Bldg. 01	Gas Equipment - Testing and Maintenance Requi CFR(s): NFPA 101 Gas Equipment - Testing and Maintenance Requirements Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other	K0924		

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K0924 Bldg. 01	Continued from page 4 flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation, and interview, the provider failed to maintain (test) the oxygen system as required. Findings include: Observation on 7/8/25 beginning at 11:42 a.m. revealed the manifold system for the oxygen in the medical gas storage room was displaying an alarm condition for both the left and right manifolds. Further observation at 1:10 p.m. revealed that the monitoring panel at the nurse's station also was showing an alarm condition visually, however the alarm was not giving an audible alarm. Interview with the DON on 7/8/25 beginning at 1:12 p.m. revealed the system had been in alarm for some time. She stated on days they had procedures they turn the system on and then at the end of those days they would turn it off. She further stated they had to do this due to the system having an unknown leak. When asked if they knew where the leak was, she stated they did not. Further interview with the maintenance supervisor at that same time revealed they did not currently have a plan in place to repair the leak, and turning it off and on was how they were dealing with the issue. Leaking oxygen presents a potential fire hazard as an oxidizing gas and needs to be always kept away from combustibles. This deficiency had the potential to affect 100% of the building occupants.	K0924	The Administrator discussed issues with oxygen line leaking with the Director of Nursing on July 31, 2025 and August 1, 2025. The oxygen has been left on for the past two weeks and is no longer leaking. Administrator will discuss rotation of oxygen cylinders with local supplier to be sure there are adequate oxygen available on procedure days. The Administrator and Director of Nursing will continue to monitor oxygen levels weekly to be sure there are no more leaks though 12/31/2025. The results of the monitoring with be included in the 3rd and 4th Quarter CQI reports.	

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 416, Subpart C, Subsection 416.54, Emergency Preparedness, requirements for ambulatory surgery centers, was conducted on 7/8/25. Brookings Ambulatory Surgery Center, LLP was found in compliance.	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael J Hurley	Administrator	08/01/2025

South Dakota Department of Health

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	53025 S	A. BUILDING: _____ B. WING _____	07/08/2025

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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 7/7/25 through 7/8/25. Brookings Ambulatory Surgery Center, LLP was found not in compliance with the following requirements: S101.	S 000		
S 101	44:76:04:10(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers are as follows: (1) Each new healthcare worker shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by:	S 101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 08/01/2025

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S 101	Continued From page 1 Based on employee file review, policy review, and interview, the provider failed to ensure a documented tuberculosis (TB) assessment had been performed on four of five sampled employees (A, C, E, and F). Findings include: 1. Review of the above listed employee files revealed: *Certified surgical technologist A: -Had been hired on 10/30/23. -Her last documented TB assessment was performed in July 2022. *RN C: -Had been hired on 7/18/24. -Her last documented TB assessment was performed on 12/13/19. *RN E: -Had been hired on 9/5/23. -Her last documented TB assessment was performed on 1/7/22. *RN F: -Had been hired on 2/27/25. -Her last documented TB assessment was performed on 12/18/20. Review of the provider's 5/14/24 TB Testing for Employees policy: *TB screening for a baseline TB risk assessment would have been required upon hire for new employees. *The TB test would not have been required if the new employee had a TB test within twelve months of hire. Interview on 7/8/25 at 11:15 a.m. with director of nursing B revealed: *She had not realized TB testing was required on all new employees within 14 days of hire, unless TB testing had been performed within one year of	S 101	Director of Nursing has reviewed all current employee records to determine compliance with Tuberculosis Assessment. If the assessment has not been completed in the proper time frame the employee will have a two-step test prior to August 22, 2025. The Administrator and Director of Nursing will review all new hire documentation within 14 days of hire to be sure the TB assessment has been completed either one year prior to hire or within 14 days after hire. The Director of Nursing will report to the Administrator when the tests have been completed. The Director of Nursing will include documentation of compliance in the 3rd Quarter CQI report.	08/22/25

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S 101	Continued From page 2 hire. *They had not followed their policy for TB assessments for the above listed employees.	S 101		