DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANCE THOMPSON VISION SURGERY CENTER	3101 W 57TH ST , SIOUX FALLS, South Dakota, 57108

(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 11/24/25 through 11/25/25. Vance Thompson Vision Surgery Center was found not in compliance with the following requirements: Q0065 and Q0181.	Q0000	FINDING: Q0065 1. Corrective Action Taken for the Specific Findings and Affected Patients The facility conducted a retrospective review of all surgical cases identified in the survey findings. Each affected patient record was reviewed to verify whether a physician evaluation and pre-surgical assessment had been completed as appropriate. Any missing or incomplete documentation will be addressed in the new corrective action plan. No adverse patient outcomes were identified. To identify other potentially affected patients, the facility reviewed a sample of several surgical cases performed during the same time period as the cited findings. This review confirmed the need for improved consistency in pre-surgical assessment documentation prior to procedure start, as well as an update to our current H&P Policy. 2. Systemic Changes Implemented to Prevent Recurrence Effective December 1, 2025, the facility revised its History & Physical (H&P) and Pre-Surgical Assessment policy to clearly define documentation requirements and responsibilities in compliance with CFR 416.42(a). The revised policy includes the following: Patients undergoing retrobulbar and/or peribulbar block procedures or surgical procedures that require the cessation of blood thinners and/or anticoagulants are required to have a current H&P completed within 30 days prior to surgery, per facility policy. All other surgical patients are required to have a documented H&P within 36 months prior to the procedure. Prior to surgery start, a pre-surgical assessment must be completed and authenticated by a physician or advanced practice provider, to evaluate the risk of the procedure to be performed. This must be documented before the procedure start time. Surgical procedures may not begin unless required documentation is completed and verified. All applicable staff and providers were educated on the revised policy and documentation requirements on December 1, 2025.	12/01/2025
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, interview, and policy review, the provider failed to ensure that a current (within 30 days) and updated history and physical (H&P) and a presurgical assessment was documented before the start of the surgical procedure for 14 of 20 sampled patients (1, 2, 3, 4, 6, 7, 10, 12, 14, 15, 16, 18, 19, and 20). Findings include: 1. Review of the 14 patient charts listed above revealed: *Patient 1: -Admitted on 5/2/25. -H&P completed on 2/10/25. -Start of the procedure was at 7:27 a.m. -Presurgical assessment was signed by the physician on 5/2/25 at 9:25 a.m. That was over an hour after the start of the surgical procedure. *Patient 2:	Q0065		

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
Alicia Hoksbergen Alicia Hoksbergen	Director of Surgery/Administrator	12/01/2025

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Q0065	Continued from page 1 -Admitted on 5/5/25. -H&P completed on 3/24/25. -Start of the procedure was at 9:03 a.m. -Presurgical assessment was signed by the physician on 5/5/25 at 10:11 a.m. That was approximately two hours after the start of the surgical procedure. *Patient 3: -Admitted on 5/19/25. -H&P completed on 5/19/25 by Surgeon F without a signature time. -Start of the procedure was at 12:52 p.m. -Presurgical assessment was signed by the physician on 5/21/25 at 2:34 p.m. That was two days after the start of the surgical procedure. *Patient 4: -Admitted on 6/2/25. -H&P completed on 5/21/25. -Start of the procedure was at 10:39 a.m. -Presurgical assessment was signed by the physician on 6/9/25 at 8:14 a.m. That was seven days after the start of the surgical procedure. *Patient 6: -Admitted on 6/13/25. -H&P Completed on 6/9/25. -Start of the procedure was at 12:12 p.m. -Presurgical assessment was signed by the physician on 6/30/25 at 11:43 a.m. The assessment was not signed until seventeen days after the surgical procedure had started. *Patient 7: -Admitted on 7/7/25. -H&P Completed on 2/10/25.	Q0065	continued from page 1 3. Monitoring Plan to Ensure Sustained Compliance WHAT will be monitored: The facility will monitor preoperative chart audits to verify the presence of an H&P within the required timeframe based on procedure type and confirmation that a pre-surgical assessment was completed, signed, dated, and timed prior to surgery start. WHO will monitor: Primary monitoring will be conducted by the ASC Pre-Op Manager, with secondary oversight by the Director of Surgery. Results will be reviewed by the Quality Assessment and Performance Improvement (QAPI) Committee. WHEN and HOW OFTEN monitoring will occur: One hundred percent (100%) of surgical cases will be reviewed for four (4) consecutive weeks following implementation. Thereafter, ten (10) charts per month will be audited for a total of twelve (12) months. Any case identified without required documentation will be reviewed on the same day and corrected prior to proceeding when possible. HOW monitoring will be incorporated into QAPI: Audit results will be summarized by the ASC Pre-Op Manager, or designee, monthly and shared quarterly with QAPI Committee and quarterly to the Governing Body. Findings and corrective actions will be documented in QAPI meeting minutes and tracked as a patient safety indicator. If noncompliance is identified, targeted provider education will occur and 100% chart review will resume for a minimum of four (4) consecutive compliant weeks. 4. Completion Date for Q0065 Completion Date: December 1, 2025	~~12/01/2025~~ AH

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Q0065	Continued from page 2 -Start of the procedure was at 2:55 p.m. *Patient 10: -Admitted on 8/8/25. -H&P Completed on 5/6/25. -Start of the procedure was at 6:52 a.m. -Presurgical assessment was signed by the physician on 8/8/25 at 9:00 a.m. That was approximately two hours after the start of the surgical procedure. *Patient 12: -Admitted on 8/19/25. -Start of the procedure was at 8:13 a.m. -Presurgical assessment was not signed by the physician. *Patient 14: -Admitted on 9/10/25. -Start of the procedure was at 9:42 a.m. -Presurgical assessment was signed by the physician on 9/12/25 at 9:25 a.m. That was two days after the start of the surgical procedure. *Patient 15: -Admitted on 9/23/25. -Start of the procedure was at 2:33 p.m. -Presurgical assessment was signed by the physician on 11/24/25 at 9:22 p.m. That was two months after the surgical procedure occurred. *Patient 16: -Admitted on 10/9/25. -H&P completed on 1/31/25. -Start of the procedure was at 8:17 a.m. -Presurgical assessment was signed by the physician on 10/10/25 at 9:13 a.m. That was one day after the surgical procedure had occurred.	Q0065		

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Q0065	Continued from page 3 *Patient 18: -Admitted on 10/23/25. -H&P completed on 7/6/25. *Patient 19: -Admitted on 11/25/25. -H&P completed on 5/12/25. -Start of the procedure was at 9:49 a.m. -Presurgical assessment was signed by the physician on 11/25/25 at 1:44 p.m. That was over three hours after the surgical procedure had occurred. *Patient 20: -Admitted on 11/24/25. -Start of the procedure was at 12:08 p.m. -Presurgical assessment signed by the physician on 11/24/25 at 12:10 p.m. That was two minutes after the start of the surgical procedure. Interview on 11/25/25 at 2:10 p.m. with ambulatory surgical center (ASC) manager A, ASC director B, and ASC executive director E revealed: *They were aware H&P's for surgical procedures were not always completed within 30 days of the procedure. *Some of their physicians had signed the pre-surgical assessments after the procedure were completed due to their workflow. *They confirmed the physicians had not followed the ASC's policy and procedure for H&P completion requirements and pre-surgical assessments. Review of the provider's May 2025 History and Physical policy revealed: *The H&P must be completed within 30 days of the surgery. *The pre-surgical assessment must be completed, signed, dated, and timed before the surgery.	Q0065		
Q0181	ADMINISTRATION OF DRUGS	Q0181		

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Q0181	Continued from page 4 CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on observation, interview, manufacturer's instruction for use (IFU) review, medication refrigerator temperature documentation review, and policy review, the provider failed to ensure: *Three of three bottles of opened proparacaine hydrochloride ophthalmic solution 0.5% (numbing medication) eye drops were stored correctly. *The temperature for one medication refrigerator in the preop/recovery area was maintained within the recommended range of 36 degrees Fahrenheit (F) to 46 degrees F. Findings include: 1. Observation and interview on 11/24/25 at 9:45 a.m. with ambulatory surgical center (ASC) manager A in the preop/recovery care unit revealed: *Three bottles of proparacaine hydrochloride ophthalmic solution 0.5% eye drops were placed in three separate baskets on the back counter behind the nurses' station. *Between administrations, the proparacaine eye drops were placed back in a basket and stored on the back counter behind the nurses' station during the day. *She confirmed: -The eye drops were taken out of the refrigerator before use, but they were not stored back in the refrigerator between uses. - At the end of each day, the eye drops were put back in the refrigerator. -The proparacaine eye drops bottles were not stored in their original cartons or in the refrigerator after opening. -It was used frequently throughout the day for many patients, and it was simpler to keep the drops on the counter instead of in the refrigerator.	Q0181	FINDING: Q0181 This Plan of Correction addresses two components of the cited deficiency: (1) medication storage not in accordance with manufacturer Instructions for Use (IFU) and (2) medication refrigerator temperatures not maintained within the recommended range with lack of documented corrective action. 1. Corrective Action Taken for the Specific Findings and Affected Patients All ophthalmic medications identified as improperly stored during the survey were removed from use and discarded per pharmacy guidance. Replacement medications were obtained and stored in compliance with manufacturer Instructions for Use (IFU). In addition, the medication refrigerator identified in the survey findings was re-calibrated and adjusted to ensure temperatures were maintained within the required range of 36–46°F. Medication integrity was reviewed in consultation with the pharmacist, and any medications with questionable temperature exposure were removed from use. To identify other potentially affected patients, the facility reviewed ophthalmic medication handling practices and medication refrigerator temperature records for the cited timeframes. No adverse patient outcomes were identified. continued on next page	12/01/2025

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Q0181	Continued from page 5 Review of the manufacturer's 2/2025 IFU of Proparacaine Hydrochloride Ophthalmic Solution 0.5% revealed: *" Storage: -Bottle must be stored in unit carton to protect contents from light. -Store bottles under refrigeration at 2°C (Celsius) to 8°C (36°F (Fahrenheit) to 46°F)." Interview on 11/24/25 at 11:09 a.m. with registered nurse (RN) C in the preop/recovery care unit regarding the storage of proparacaine hydrochloride ophthalmic solution 0.5% eye drops revealed: *Each day, the eye drops were taken out of the refrigerator and placed in individual baskets on the back counter behind the nurses' station to be used throughout the day. *At the end of each day, the eye drops were stored back in the refrigerator. *She was unaware of the storage guidelines for the eye drops. Interview on 11/25/25 at 11:30 a.m. with pharmacist D regarding the storage of proparacaine hydrochloride ophthalmic solution 0.5% eye drops revealed he: *Was unaware that the staff were not refrigerating the eye drops between uses. *Stated, "Generally, they shouldn't be left out all day." *Would have recommended to the provider that the eye drops be stored back in the refrigerator between uses, as directed by the manufacturer's IFU. Review of the provider's 5/25 Instillation of Eye Drops and Administration of Eye Ointments policy revealed, "Ophthalmic medications may be stored at room temperature unless the label indicates refrigeration is necessary." Review of the provider's 5/25 Medication Storage policy revealed, "Medications are stored under the proper conditions as recommended by the United States Pharmacopoeia, product labeling, and/or package inserts." 2. Review of the provider's weekly temperature sensor	Q0181	2. Systemic Changes Implemented to Prevent Recurrence Effective December 1, 2025, the facility implemented system changes addressing both components of the deficiency. Medication Storage: Ophthalmic medications, including proparacaine hydrochloride 0.5%, are stored in their original unit cartons to protect from light. Medications requiring refrigeration are stored at 36–46°F at all times. Proparacaine eye drops are returned to refrigeration between each patient use. Medication Refrigerator Temperature Monitoring: Medication refrigerator has been -recalibrated to the acceptable temperature range of 36–46°F. Real-time alerts will be sent to ASC Pre-Op Manager and Director of Surgery for immediate corrective action and documentation when temperatures fall outside the acceptable range. This will be re-routed to designee in the absence of leadership team. A required one-hour temperature recheck will immediately follow any corrective action. A mandatory pharmacist consultation will occur if temperatures remain out of range for greater than 24 hours or medication integrity is in question. The Surgery Center Director and ASC Pre-OP Manager reviewed the Medication Refrigerator Temperature Log documentation to ensure corrective actions, rechecks, pharmacist notification, and final resolution will be included in each occurrence. All applicable staff were re-educated on medication storage requirements, manufacturer IFUs, and medication refrigerator temperature monitoring and documentation expectations on December 1, 2025. continued on next page	~~12/01/2025~~ AH

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Q0181	Continued from page 6 reports regarding the preop/recovery area medication refrigerator revealed: *The refrigerator was not continuously maintained within the recommended range of 36°F to 46°F for the following days reviewed. -Seven of seven days reviewed from 9/12/25 through 9/18/25. -Twenty-one of twenty-eight days reviewed from 10/24/25 through 11/20/25 *No corrective action and additional monitoring of temperatures for these dates were documented. Interview on 11/25/25 at 9:00 a.m. with the ASC manager A and the ASC B Director revealed: * The medication fridge in the preop/recovery area was programmed to alarm when temperatures exceeded the recommended ranges. * The leadership team was in charge of monitoring temperatures and responding to any alarms. * ASC manager A stated that the temperatures would have been adjusted to ensure they were within the recommended range. * There was no documentation to support any corrective actions taken to address the out-of-range temperatures of the medication refrigerator. * There was no additional monitoring of temperatures on the log if the temperatures were outside the acceptable range. * ASC manager A stated that if the medication refrigerators were out of range for an extended period (more than 24 hours), the pharmacist was consulted. There was no documentation to support this. Interview on 11/25/25 at 11:30 a.m. with pharmacist D revealed: * He was unaware that the medication refrigerator in the preop/recovery area had been out of range. * If the medication refrigerators were out of range, staff would call, and he would decide if the product was damaged. *During his monthly visits, he monitors the temperature	Q0181	3. Monitoring Plan to Ensure Sustained Compliance WHAT will be monitored: The ASC Pre-OP Manager and Surgery Center Director, or designee, will monitor medication storage audits to verify ophthalmic medications are stored in compliance with manufacturer IFUs and medication refrigerator temperature logs to confirm temperatures remain within the acceptable range of 36–46°F, including documentation of corrective actions, one-hour rechecks, and pharmacist notification when required. WHO will monitor: Daily medication refrigerator temperature monitoring and documentation will be performed by designated nursing staff. Weekly review and validation of monitoring logs and medication storage practices will be conducted by the ASC Pre-Op Manager. Oversight and trend analysis will be provided by the ASC Pre-Op Manager to the Director of Surgery and Director of Nursing. Results will be reviewed by the Quality Assessment and Performance Improvement (QAPI) Committee. WHEN and HOW OFTEN monitoring will occur: Refrigerator temperatures will be monitored and documented daily on each day the facility is open. Temperature logs will be reviewed weekly for twelve (12) consecutive weeks and monthly thereafter for a total monitoring period of twelve (12) months. Medication storage audits will be conducted weekly for twelve (12) weeks and monthly thereafter for the remainder of the monitoring period. HOW monitoring results will be incorporated into the Quality Assessment system: Monitoring results will be summarized by the ASC Pre-Op Manager and reported quarterly to the QAPI Committee and quarterly to the Director of Surgery, Director of Nursing and Governing Body. Compliance will be tracked as a Medication Management and Patient Safety performance indicator, with findings, trends, and corrective actions documented in QAPI meeting minutes. If noncompliance is identified, immediate corrective action and staff re-education will occur, and weekly audits will resume until sustained compliance is demonstrated. 4. Completion Date for Q0181 Completion Date: December 1, 2025	~~12/01/2025~~ AH

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Q0181	Continued from page 7 logs. -The 9/25/25 and 10/20/25 Pharmacy Consult Audit Tool showed that temperature logs were marked as compliant. Review of the providers' 5/2025 medication refrigerator policy revealed: *The acceptable temperature range was 36°F to 46°F. * "If the temperature falls outside this range, the problem should have been corrected immediately by adjusting the thermostat up or down, and the temperature rechecked in one hour. * Corrective action and subsequent temperature monitoring will be documented on the medication refrigerator log." *The pharmacist consultant should have been contacted concerning drug storage when temperature readings fall outside the acceptable range.	Q0181		

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K0000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing ambulatory health care occupancy) was conducted on 11/25/25. Vance Thompson Vision Surgery Center was found not in compliance with 42 CFR 416.44 (b)(1) requirements for Ambulatory Surgical Centers. The building will meet the requirements of the 2012 LSC for existing ambulatory health care occupancies upon correction of the deficiency identified at K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	FINDING: K0923 1. Corrective Action Taken for the Specific Findings and Affected Areas Immediately upon identification of the deficiency, combustible materials stored within five feet of oxygen cylinders in the medical gas room were removed. Plastic covers and other combustible items were relocated to an appropriate disposal area away from medical gas storage. All oxygen cylinders in the medical gas room were evaluated. Cylinders attached to the manifold and spare cylinders were properly restrained to prevent falling. All cylinders were clearly labeled to identify full versus empty status in accordance with NFPA requirements.	12/18/2025
K0923 Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage *Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. *Greater than 300 but less than 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating. *Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each	K0923	No other medical gas storage locations are present within the building, so further inspection was not required outside of the one location. 2. Systemic Changes Implemented to Prevent Recurrence Effective December 18, 2025, the facility implemented system changes to ensure ongoing compliance with NFPA 99 and NFPA 101 medical gas storage requirements. These changes include: Revision of internal medical gas storage procedures to clearly define requirements for securing cylinders, maintaining required separation from combustible materials, and labeling cylinders as full or empty. Designation of approved storage locations for medical gas cylinders and prohibition of combustible material storage within required clearance zones. Coordination with the medical gas supplier to review facility storage requirements and expectations for cylinder delivery and placement. Education of leadership and applicable staff on Life Safety Code medical gas storage requirements and routine inspection expectations. continued on next page	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Hoksbergen Alicia Hoksbergen	Director of Surgery/Administrator	12/18/2025

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K0923 Bldg. 01	Continued from page 1 door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored within five feet of the oxygen cylinders, oxygen cylinders were not adequately restrained, and oxygen cylinders were not clearly marked as full or empty at one randomly observed location (medical gas room). Findings include: 1. Observation on 11/25/25 at 8:11 a.m. revealed combustible materials were stored adjacent to and within five feet of the fifteen "G" sized oxygen cylinders in the medical gas room. The left set of five tanks attached to the manifold and the five spare cylinders secured to the left wall had two separate, approximately thirteen-gallon sized bags, full of plastic covers removed from the top of other oxygen cylinders. Those bags of plastic covers were hung from the anchors for the chain used to secure the spare cylinders were combustible, and within five feet of those cylinders. Continued observation at that same time revealed the status (full or empty) of the spare cylinders located in that room had not been labeled in any fashion. Further observation at that same time revealed the ten cylinders attached to the manifold at their outlets with soft copper tubing, were not restrained from falling over by anything other than the outlet tubing. The oxygen storage requirements for being stored securely, maintaining the minimum of five feet of separation from combustibles, and being clearly marked were not as required in that area.	K0923	3. Monitoring Plan to Ensure Sustained Compliance WHAT will be monitored: The facility will monitor compliance with medical gas storage requirements, including verification that oxygen cylinders are properly secured, clearly labeled as full or empty, and maintained with a minimum five-foot separation from combustible materials. WHO will monitor: Primary monitoring will be conducted by an ASC Manager or designee. Oversight will be provided by the Director of Surgery and the Quality Assessment and Performance Improvement (QAPI) Committee. WHEN and HOW OFTEN monitoring will occur: Medical gas storage areas will be inspected weekly for twelve (12) consecutive weeks following implementation of corrective actions. Thereafter, inspections will be conducted monthly for a total monitoring period of twelve (12) months. HOW monitoring results will be incorporated into the Quality Assessment system: Inspection results will be documented on a Life Safety monitoring tool and summarized by the ASC Manager. Results will be reported quarterly to the QAPI Committee, Director of Surgery, and Governing Body. Any identified deficiencies will prompt immediate corrective action and staff re-education, with increased monitoring until compliance is re-established. 4. Completion Date for K0923 Completion Date: December 18, 2025	~~12/18/2025~~ AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001027	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 01** B. WING	(X3) DATE SURVEY COMPLETED **11/25/2025**

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K0923 Bldg. 01	Continued from page 2 Interview with the ambulatory surgical center manager at that same time confirmed those findings. She stated she was unaware those oxygen cylinders were stored in that manner in that location. She further stated she was unaware the medical gas supplier was not following the requirements of oxygen cylinders being stored securely, the minimum five feet of separation from combustibles, and being clearly marked as full or empty. The deficiency had the potential to affect all occupants of the smoke compartment.	K0923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001027	A. BUILDING B. WING	11/25/2025

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E0000	Initial Comments A recertification survey was conducted on 11/25/25 for compliance with 42 CFR 416.54, Emergency Preparedness, requirements for ambulatory surgery centers. Vance Thompson Vision Surgery Center was found in compliance,	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Hoksbergen	Director of Surgery/Administrator	12/19/2025

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
	65416 S	A. BUILDING: _____ B. WING _____	11/25/2025

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S 000	Compliance/Noncompliance A licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted from 11/24/25 through 11/25/25. Vance Thompson Vision Surgery Center was found in compliance.	S 000		

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

Alicia Hoksbergen

TITLE: Director of Surgery/Administrator

(X6) DATE: 12/19/2025