STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11152 S	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLASTIC SURGICAL CENTER OF RAPID CITY, PROF	3615 5TH ST SUITE 100 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 092	Continued From page 1 interview, and policy review, the provider failed to ensure six of six sampled staff (B, C, E, F, G, and H) had reappointment of privileges within a two-year time period. Findings include: 1. Review of the credentialing files for certified registered nurse anesthetists (CRNAs) C and H revealed their current reappointment for privileges was from 3/1/22 through 3/1/25, a period of three years. 2. Review of the credentialing files for physicians B, E, F, and G revealed: *Physician B and E's current reappointment for privileges was from 3/1/22 to 3/1/25, a period of three years. -Their previous appointments were for three years from 3/31/19 to 3/31/22. *Physician F's current appointment for privileges was from 4/16/21 to 4/16/24, a period of three years. *Physician G's current reappoint for privileges was from 3/1/22 to 3/1/25, a period of three years. 3. Interview on 9/12/23 at 4:00 p.m. with facility director A regarding the reappointment of medical staff privileges revealed: *"We [the governing body board] went by AAAHC (Accreditation Association for Ambulatory Health Care) standards." -Those standards indicated reappointment was to have been conducted every three years. *She was not aware of the two-year guideline for reappointment of privileges. 4. Review of the provider's Governing Body By-laws revealed: *"Section 3.10 Term of Appointment" -"(a) Appointments to the medical staff shall be	S 092	The Director of PSC reviewed the credentialing files for the CRNA's and physicians. Two of the providers are up for re-appointment. That process is currently being completed. The other 8 providers 2-year re-appointments for privileges are February to March 2024. The Director will annually review the credentialing files to ensure accurate time frames for re-appointments. Annual review of charts will also include monitoring for current licenses and certifications, proof of insurance, and if applicable proof of DEA certificates. The National Practitioner Data Bank (NPDB) Query will be used to monitor for any suspensions, grievances, and malpractice claims that would affect the providers ability to continue provide services at PSC. The Medical Director and Chairman of the Board will review the information and sign off on approval or disapproval of the provider. A letter will be sent to the provider notifying them of their status. The policy for re-appointment or privileges has been updated to reflect every 2-year review, as it was previously on an every 3-year basis.	10/23/23

South Dakota Department of Health

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S 000	Compliance/Noncompliance A licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted from 9/11/23 through 9/14/23. Plastic Surgical Center of Rapid City, Prof LLC was found not in compliance with the following requirements: S092 and S096.	S 000		
S 092	44:76:04:03 Medical Staff A facility shall have a medical staff organized under bylaws and rules approved by the governing body and responsible to the governing body for the quality of all medical care provided patients in the facility and for the ethical and professional practices of its members. The medical staff shall include physicians, but it may also include other practitioners appointed by the governing body. If the medical staff has an executive committee, a majority of the members of the committee shall be physicians. The responsibility for the conduct of medical staff affairs shall be assigned to an individual physician. The medical staff shall establish a credentials committee to review the qualifications of practitioners applying for admitting or patient care privileges and recommend to the governing body practitioners eligible for appointment to the medical staff by the governing body. The review shall include recommendations regarding delineation of admitting and patient care privileges. The medical staff shall conduct appraisals of its members at least every two years. The review shall include recommendations regarding delineation of privileges. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee credential file review,	S 092		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Wiles RN — TITLE: Director — (X6) DATE: 10/18/23

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S 092	Continued From page 2 made by the Governing Body for a period of three (3) years or until terminated by the Governing Body." Review of the provider's undated Medical Staff Re-Appointment policy revealed "All physicians will complete an "Application for Re-Appointment" every three years based on their anniversary date.	S 092	A new policy was created for employee annual training & new employee onboarding. This policy states the employee will receive facility training on policies and procedures of PSC, as well as the subjects that are required by state and federal regulations. Fire prevention & response, infection control & prevention, accident and safety, patient rights, confidentiality, mandatory reporting and disease reporting, and care of patients with unique needs. This facility does not house or use restraints. PSC annual training occurs every September or October depending on schedules. This 2023 annual training took place on 1010/23. The above information was covered, the newly appointed Infection Prevention (IP) nurse reviewed CDC, APIC, and AORN guidelines as well as specific policies and procedures of PSC. A new process for staff was put in place in regard to taking out garbage and hazard materials; OR staff will no longer step outside the facility with their surgical attire on. Other ancillary staff will take these items to the outside receptacles. All staff are required to attend and participate in the annual training. Any staff members that are unable to attend the trainings will have a 1:1 meeting with the Director within 2 weeks of the annual training. This meeting will cover the information that occurred in training. The Director ensures staff are trained and accountable to training attendance. The Emergency Management Coordinator (EMC) will discuss the disaster management policy and checklist. One of the required code drills will be completed. The QAPI nurse discussed current PSC QI studies and introduced a new study that will be initiated January 2024 in regard to patient education and decreased post-op difficulties once discharged home. The IP nurse is developing a study to follow up with patients 2 weeks post op to monitor for CAUTI's on patients that had foleys and or straight cath procedures. The Director, QAPI, and IP nurse will report QAPI studies/results quarterly to staff and the board. Studies are available for review at any time to staff and providers of PSC.	
S 096	44:76:04:06 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Patient rights; (7) Confidentiality of patient information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; and (9) Care of patients with unique needs; Personnel whom the facility determines will have no contact with patients are exempt from training required by subdivisions (5) and (9) of this section. Additional personnel education shall be based on facility identified needs.	S 096		10/23/23

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S 096	Continued From page 3 Current professional and technical reference books and periodicals shall be made available for personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled employees (A and I) had completed annual training. Findings include: 1. Review of the director of nursing (DON) A's employee file revealed: *She had been hired on 7/18/22. *There was no record indicating the annual training had been completed since the initial orientation. 2. Review of surgery technician (ST) I's employee file revealed: *She had been hired on 10/21/2010. *There was no record indicating the annual training had been completed. 3. Interview during the entrance conference on 9/11/23 at 2:00 p.m. and on 9/12/23 at 5:45 p.m. with director A revealed: *She had assumed the role of the facility director in August 2023. -She was also the director of nursing services. *She was responsible for ensuring continuing education of the staff. *She had staff go through facility policies upon hire, but there had been no annual staff training other than fire safety and emergency preparedness drills. -"I would highly doubt annual training on topics has occurred [in the past]."	S 096	The Director has purchased a subscription to APIC and the facility has access to the AORN site as well as computer resources from CDC, CMS, and DOH that they are able to access. Videos, magazines, and books are available for staff learning/review. Hand washing, OSHA, and disease reporting information. Staff and the IP nurse can access AORN and APIC sites. The IP nurse has taken training courses on APIC in regard to infection control and prevention knowledge and maintaining current standards are followed. Staff educated by the director on importance of professional development. Staff is aware the administration of PSC will assist with any educational opportunities to enhance learning in relation to their job role.	10/23/23 10/23/23

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S 096	Continued From page 4 4. Interview on 9/13/23 at 9:50 a.m. with ST J regarding annual training revealed: *She had been employed at this facility for nearly one-and-a-half years. *She had completed an initial hire training booklet. -That booklet covered various topics that included, "Fires, mental health crisis, storms, emergency preparedness, and codes [cardio-pulmonary resuscitation]." -She could not recall receiving any annual training other than what she completed on her own. An annual staff training policy was requested on 9/12/23 at 5:15 p.m. At 5:45 p.m., director A informed the survey team there was no policy located. Review of the provider's 2013 'Director of [facility name]' job description revealed: *"Educational Responsibilities" -"A. Provide for personal and professional growth and development of nursing personnel by providing continuing education of staff through regular in service programs and authorize time off and/or obtain financial assistance for attending appropriate seminars." -"B. Assume responsibility for personal continuing education and developmental needs."	S 096		

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PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , RAPID CITY, South Dakota, 57701

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Q0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 416, Subpart C; requirements for Ambulatory Surgery Centers (ASC), was conducted from 9/11/23 through 9/13/23. Plastic Surgical Center of Rapid City, Prof LLC was found not in compliance with the following requirement: Q181.	Q0000		
Q0181	ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Medications were stored in a locked cabinet and refrigerator that was inaccessible to patients or visitors. *Storage of the narcotic medication keys were kept in a secured area and only accessible to assigned staff. Findings include: 1. Initial facility tour on 9/11/23 from 2:45 p.m. through 3:30 p.m. revealed: *In the post-anesthesia recovery room (PAR) there were three unlocked wooden slat door upright cabinets along the right side of the wall that contained various patient supplies. *The middle-unlocked cabinet consisted of multiple shelves of intravenous (IV) supplies and medications including the following: -14 intravenous (IV) solution bags containing the antibiotic agent ciprofloxacin.	Q0181		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Wilson RN	Director	10/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2023

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Q0181	Continued from page 1 -50 individual injectable vials of the antibiotic agent cefazolin. -15 individual dose tablets of the antibiotic agent clindamycin. *The same middle unlocked cabinet also had an unlocked compact refrigerator on the lowest shelf containing the following: -19 individual vials of the injectable paralytic (to cause a person or part of the body to lose the ability to move or feel) agent succinylcholine 200mg(milligrams)/10ml(milliliters). -6 individual vials of the injectable paralytic agent Rocuronium bromide 100mg/10ml. -43 individual vials of the injectable antacid agent famotidine 20mg/2ml. -11 individual vials of the injectable nerve-blocking agent Exparel 1.3% 133mg/10ml. -1 multi-dose vial of the injectable blood sugar lowering agent Humulin R insulin. -2 multi-dose vials of the tuberculosis skin testing agent Tuberculin 5 TU (tuberculin units). Interview on 9/11/23 at 4:00 p.m. with facility director A regarding the unlocked medications in the PAR room revealed: *Family members and visitors were allowed to visit the patient in the PAR room. -The patient would have been discharged in the care of a support person directly from the PAR room. *She agreed these medications could have been accessed by patients and visitors and should have been stored in a locked cabinet and a locked refrigerator. 2. Observation and interview on 9/11/23 at 4:00 p.m. and on 9/13/23 at 1:45 p.m. with facility director A revealed: *Narcotic medications were kept double locked in a metal box located in a locked cabinet in the PAR room.	Q0181	The refrigerator housing the Succinylcholine an Rocuronium is now locked with a combination code. This code is known only by CRNAs, RN's and the pharmacist. Staff members that are not involved in direct patient care or medication administration do not have access to this refrigerator code. The Director of PSC will monitor the narcotic count log book on a daily basis to ensure accuracy and monitoring to prevent drug diversion. The Pharmacist visits facility 2 - 4 times a month and does an inventory count on the narcotic medications at PSC as well as monitors/reviews the narcotic log. Any discrepancies will be first reported to the Medical Director and the proper channels of notifying the DEA, local law enforcement, state board of pharmacy, state board of nursing, and PSC pharmacist will take place. The combination code to the refrigerator will be changed any time a staff member is no longer employed by PSC or if the code number security has been breached for any reason. Each time the code is changed a log form in the narcotic book will state the date and reason the code was changed. The narcotic keys are no longer kept in a bag in the file cabinet that all staff have access to. The narcotic keys have been placed in a lock box with a combination code that only the CRNAs, RNs, and pharmacist have knowledge of. The log box is placed in the locked cabinet attached to the wall in the front office. Security cameras have been placed in the front office, hallway, and breakroom. The front door has a combination code with each employee having their own code, if an employee leaves or is terminated their code is inactivated and unable to be programmed again. Cameras are monitored on a daily ongoing basis by the Director of PSC, any suspicious activity will be reported to the Medical Director and Board of Directors by the Director of PSC and the proper authority channels will be notified.	10/23/23 10/23/23

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Q0181	Continued from page 2 -The nurse and the anesthetist would carry the keys to the narcotic cabinet during office hours. *When the office was closed, the keys to the narcotic medication cabinet were stored in a locked file cabinet located in the front office. -The key to open the file cabinet was unsecured and sitting out on a shelf in the front office. -All staff knew the file cabinet key's location and where the narcotic keys were stored. *Director A stated that had always been the process for storing the narcotic keys. -"That has been something that has bothered me. I'm trying to catch up with all the needed changes [since becoming director]." *Agreed there could have been a potential for diversion by having the narcotic keys accessible to any staff member. Review of the provider's Pharmaceutical Services policy revealed: *"STORAGE AND LABELING OF PHARMACEUTICALS" -"1. All medications are stored in locked cabinets and are inaccessible to patients, or visitors." -"a. Operating Room medications are located in locked cabinets on the west wall in the O.R." -"b. Anesthesia medications are located in the locked anesthesia cart and the locked cabinets behind the anesthesia cart." -"c. PAR medications are located in the locked cabinets on the west wall of the PAR." -"e. Medications requiring refrigeration are in the refrigerator located in PAR." -"f. All Schedule II controlled medications are stored in a double-locked, securely fastened box in the Operating Room." *"CONTROL AND ACCOUNTABILITY OF PHARMACEUTICALS" -"4. All floor stock medication will be secured in locked cabinets."	Q0181		

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Q0181	Continued from page 3 -"5. b. Narcotic keys are restricted nursing staff and storage of same is known only to nursing director and medical director." ""PROCEDURE:" -"4. b. The PACU [PAR] nurse will obtain the keys each morning from the Director or his/her designee and return them to her in the evening after the daily narcotic count."	Q0181		

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

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E0000	Initial Comments A recertification health survey for compliance with 42 CFR Part 416, Subpart C, Subsection 416.54, Emergency Preparedness, requirements for ambulatory surgery centers (ASC), was conducted from 9/11/23 through 9/13/23. Plastic Surgical Center of Rapid City, Prof LLC was found not in compliance with the following requirement: E001.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 416.54 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must 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: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	E0001		

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
Stephanie Wilson RN	Director	10/18/23

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E0001	Continued from page 1 *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on interview and emergency preparedness (EP) program review, the provider failed to have a comprehensive emergency preparedness program. Findings include: 1. Review of the provider's 2022 Disaster Plan revealed: *"This plan will focus on how the facility would function to assist the community in handling multiple casualties. By describing how the facility would mobilize to its maximum abilities the plan will be expected to cover any of the varying degrees of need, including internal and external disasters." *The EP manual Survey & Certification Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning was a list of tasks that would have required completion in the event of an emergency. *The disaster plan had not provided direction as how to complete the required emergency preparedness checklist requirements. *There was no specific information regarding: -Emerging infectious diseases. -Continuity of operations to include delegations of authority and succession plans. -The process of collaborating with State and Federal emergency preparedness official's efforts to maintain an integrated response during an emergency. -A system to track the location of on-duty staff and sheltered patients during an emergency. -Information regarding the specific name and location of the receiving facility or other location.	E0001	A policy for Emerging Infectious Diseases is available for PSC staff. This policy covers how to identify, isolate, and inform the DOH. The annual training on10/10/20 staff were educated on this policy as well as new reporting requirements of the DOH. Included in this policy is a list of Reportable Diseases in South Dakota. A Disaster Checklist was developed for PSC staff to guide them in the event of a disaster. This list gives staff the authority during a disaster as well as how staff can maintain operations within PSC while addressing any emergencies that are occurring. PSC hs an Emergency Management Coordinator (EMC). This individual is a member of the BH Coalition and SD Emergency Preparedness group. the EMC attends meetings & trainings in regard to potential hazards & emergencies in our area, as well as how to report & reach out to resources. The EMC brings any new information to the staff at PSC & takes part in training at the annual staff meetings. The EMC is notified via the EICS of any disasters or events occurring. PSC is a small (less than 2500 sq ft) one level facility with a small staff. The Director has a schedule of all staff on duty each day and a list of patients in the facility each day. In the event of an emergency. A central internal and external gathering area has been established. The EMC through BH Coalition is advised of HAvBED at Monument Hospital should an emergency occur.	10/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , 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
E0001	Continued from page 2 -Complete information on safe evacuation from the facility that considered care and treatment needs of evacuees, staff responsibilities, identification of evacuation locations, and alternate means of communication with external sources for assistance. -The development and implementation process for sheltering in place. -A system of medical documentation that preserved patient information, protected the confidentiality of patient information, and secured and maintained the availability of medical records. -A communication plan that addressed the following: --Revision every two years. --Names of contact information for staff, entities providing services under contract, and patient physicians. --Contact information for federal, state, tribal, regional, and local emergency preparedness personnel. --Primary and alternate means for communicating with facility staff, federal and state, tribal, regional, and local emergency management agencies. *A method for sharing information and medical documentation for patients under the facility's care with other healthcare providers to maintain continuity of care. *A means to release patient information in the case of an evacuation. *A means of providing information regarding the general condition and location of patients. *A means of providing information about the facility's needs. *Process for training and testing of the emergency preparedness of the disaster plan and updating the plan every two years. *Initial staff training and training thereafter on the emergency preparedness plan every two years to include their roles and responsibilities. *Maintaining documentation of staff training and competency in emergency procedures.	E0001	Specific lists for evacuation routes, assembly points, first aid, patient secure charting & secure method of protecting patient information in the event of a transfer from PSC, patient & staff tracking. Within the checklist, staff can find a list of communication and resources available as well as utility numbers, numbers to transferring facilities and emergency assistance numbers. The checklist also includes a guide of staff responsibilities should an event occur. Within the policy and checklist information for staff on how to care for staff and patients that may be injured or need medical care, or if patients injured in the community are sent to PSC for care. Should the computer system become unavailable, a process of paper charting is in the emergency kit as well as, a method to keep paperwork secure if a transfer is in place by individual sealed envelopes. The Disaster Policy and Disaster Checklist will be reviewed every 2 years or more often if needed. Revisions will occur as needed as well as every 2 years. Physician & staff contact information (calling tree) including administration contact information, emergency and support assistance and transfer facility information is included in the checklist. The EMC and the Disaster Checklist include numbers to local & regional personnel to assist during a disaster. Contacting the EMC and utilizing the EICS system would be first line of action. In addition, PSC would utilize phone systems or cell phones in the case of an emergency or disaster. In the event of no phone lines available, the Medical Director and Director would determine if it was safe for a staff member to leave the facility to find assistance. Should the computer charting system be unavailable, paper charts and wrist bands for patient identification are included in the emergency kit. Envelopes that can be sealed to contain paper charts for confidentiality and secure the patient information included in the emergency kit. In the event of an emergency, staff will be assigned roles. Role of the Medical Director, Director, and CRNA will guide and communicate with staff in regard to care and status of patients. The Medical Director, Director and EMC will communicate with local & state agencies in regard to status of PSC and needs of the facility by utilizing the EICS system, emergency resources via phone. If those services are unavailable, it will be determined by the Medical Director if it is safe to leave the facility to go for help. Participating in statewide disaster drills and required annual drills that PSC participates in will allow the Director and the EMC to test and evaluate the emergency preparedness plan and make revisions as needed. New hire staff will be trained by the Director upon hire as to the emergency plan and checklist for PSC. Annually, staff will attend and actively participate in the annual trainings and participate in the 4 annual fire drills & 2 other required drills. Upon completion of drills, a drill report form will be completed by the Director &/or EMC to evaluate effectiveness of the drill and staff response to the drill performed. This assessment will include education and troubleshooting to make necessary changes to the emergency preparedness plan.	10/23/23

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	43C0001026	A. BUILDING B. WING	09/13/2023

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PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , RAPID CITY, South Dakota, 57701

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E0001	Continued from page 3 *Process for conducting an analysis of the facility's response in the event of an emergency. Interview and review of the facility's emergency plan on 9/13/23 at 1:10 p.m. with director A confirmed the above items were not completely addressed in the current emergency preparedness plan.	E0001	Following each drill, the Director &/or EMC will analyze the drill report sheet. This will allow for time sensitive changes that may need to be made to better the facility's training and response. During review of the emergency preparedness plan, the Director & EMC will again review the drills as well as the emergency preparedness policy and checklist to make necessary changes.	10/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43C0001026	A. BUILDING 01 - BUILDING 01 B. WING	09/14/2023

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PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , RAPID CITY, South Dakota, 57701

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/14/23. Plastic Surgical Center of Rapid City, Prof LLC was found in compliance with 42 CFR 416/44(b)(1) requirements for Ambulatory Surgical Centers.	K0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Wilson RN OCT 06 2023	Director	10/6/23

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
	11152 S	A. BUILDING: _____ B. WING _____	R 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLASTIC SURGICAL CENTER OF RAPID CITY,	3615 5TH ST SUITE 100 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 An onsite revisit licensure survey for compliance with Administrative Rules of South Dakota 44:76, requirements for ambulatory surgical services, was conducted on 10/26/23. Plastic Surgical Center of Rapid City, Prof was found in compliance.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	43C0001026	A. BUILDING B. WING	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , RAPID CITY, South Dakota, 57701

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Q0000	INITIAL COMMENTS An onsite revisit survey was conducted on 10/26/23 for compliance with 42 CFR Part 416, Subpart C; requirements for Ambulatory Surgery Centers (ASC) for all previous deficiencies cited on 9/13/23. All deficiencies have been corrected and no new non-compliance was found. Plastic Surgical Center of Rapid City, Prof, LLC was found in compliance with all regulations surveyed.	Q0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43C0001026	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLASTIC SURGICAL CENTER OF RAPID CITY, PROF LLC	3615 5TH STREET SUITE 100 , RAPID CITY, South Dakota, 57701

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E0000	Initial Comments An onsite revisit survey was conducted on 10/26/23 for compliance with 42 CFR Part 416, Subpart C; requirements for Ambulatory Surgery Centers (ASC) for all previous deficiencies cited on 9/13/23. All deficiencies have been corrected and no new non-compliance was found. Plastic Surgical Center of Rapid City, Prof, LLC was found in compliance with all regulations surveyed.	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.

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