PRINTED: 03/05/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2025		
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 W 2ND ST POST OFFICE BOX 420 , REDFIELD, South Dakota, 57469				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TION SHOULD BE COMPLE CED TO THE DATE		
G0000	INITIAL COMMENTS A recertification health survey CFR Part 484, Subparts B-C, Health Agencies, was conducted 2/5/25. Community Memorial found in compliance.	requirements for Home cted from 2/4/25 through	G0000				
Any deficienc	v statement ending with an ast	erisk (*) denotes a deficiency which	45- :	titution may be excused from correcting pro			

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 REPRESI	TITLE	(X6) DATE	
Karen Spirseth		CEO	03/12/2025
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 65324-H1	Facility ID: SD437055	If continuation sheet Page 1 of 1

FORM APPROVED OMB NO. 0938-0391

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDENTIFIC 437055		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER: 437055	VIDER/SUPPLIER/CLIA CATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2025	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E0000 Initial Comments A recertification survey for compliance with 42 CFR Part 484, Subpart G, Subsection 484.102 Emergency Preparedness Requirements for Home Health Agencies, was conducted from 2/4/25 through 2/5/25. Community [EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION DATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E0000 [E0000] [E0000]				1031 W 2ND ST POST OFFICE BOX 420 , REDFIELD, South				
A recertification survey for compliance with 42 CFR Part 484, Subpart G, Subsection 484.102 Emergency Preparedness Requirements for Home Health Agencies, was conducted from 2/4/25 through 2/5/25. Community	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE			COMPLETION	
	E0000	A recertification survey for co Part 484, Subpart G, Subsec Preparedness Requirements conducted from 2/4/25 through	tion 484.102 Emergency for Home Health Agencies, was gh 2/5/25. Community	E000	000			

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
Karen Spurseth

TITLE

(X6) DATE

03/12/2025