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

PRINTED: 03/07/2024 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		PENDING	B. WING			02	/28/2024
NAME OF PROVIDER OR SUPPLIER CUSTER CARE AND REHAB CENTER				10	TREET ADDRESS, CITY, STATE, ZIP CODE 065 MONTGOMERY ST CUSTER, SD 57730		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An initial certification compliance with 42 Crequirements for Long	health survey for FR Part 483, Subpart B, g Term Care facilities was '24 through 2/28/24. Custer		0000			
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
	Van Voorst				Administrator		3/19/24

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a ptan 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

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FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID U0W411

Facility ID: 0135

If continuation sheet Page 1 of 1

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED	
		PENDING	B. WING		02/27/2024
	ROVIDER OR SUPPLIER	TER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 712 SS=C	the life safety code (L care occupancy) was Custer Care and Rehacompliance with 42 C for Long Term Care Filter The building will meet 2012 LSC for existing upon correction of def K325, and K712 in cocommitment to continusafety standards. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the taignal and simulation conditions. Fire drills aunexpected times und least quarterly on each with procedures and is established routine. We between 9:00 PM and announcement may be alarms. 19.7.1.4 through 19.7. This REQUIREMENT by: Based on observation failed to ensure staff we provider's fire drill procannouncement, activate checking the door for bringing fire extinguish Findings include:	survey for compliance with SC) (2012 existing health conducted on 2/27/24. ab Center was found not in FR 483.70 (a) requirements acilities. the requirements of the health care occupancies iciencies identified at K321, njunction with the provider's used compliance with the fire are held at expected and fer varying conditions, at his shift. The staff is familiar is aware that drills are part of Where drills are conducted 6:00 AM, a coded is used instead of audible 1.7 is not met as evidenced in and interview, the provider were familiar with the cedures (alarm ting the fire alarm system,	K 712	Maintenance director or designee wieducate all staff on proper fire drill procedure by 3/29/24. Maintenance Director or designee waudit staff for proper education on fir procedure weekly for four weeks and monthly for two additional months Maintenance director or designee wireport findings at monthly QAPI mee	rill re drill d
ABORATORY D	IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Samuel Van Voorst

Administrator

3/19/24

Any deficiency statement ending with an asterisk (*) penotes a deficiency writch the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the penets (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan or 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 certain perfect pless are cited, an approved plan of correction is requisite to continued program participation.

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID U0W42

Facility ID: 0135

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

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		IDENTIFICATION AND MADED.		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		COMPLETED	
		43A140	B. WING_			02/27/2024	
NAME OF PROVIDER OR SUPPLIER CUSTER CARE AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730			
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 712	fire drill was initiated if first staff person responsive to the alarm was not initian announced until promotation and not perform door check for heat. It brought to the fire drill interview with the mattime of the above obstindings. He stated the for the provider at that	27/24 at 2:45 p.m. revealed a n resident room 104. The conding to the simulated fire resident to a safe location. It is a safe location. It is a safe location to the simulated or lapted to do so. The second lang to the simulated fire rm an acceptable closed location in the location in tenance supervisor at the servations confirmed those is a fire drill was the first one	K	712			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
i		PENDING	B. WNG_			02/28/2024		
NAME OF PROVIDER OR SUPPLIER CUSTER CARE AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD B			
E 000	482, Subpart B, Subs Preparedness, requir facilities was conduct 2/28/24. Custer Care found in compliance.	compliance with 42 CFR Part section 483.73, Emergency rements for Long Term Care sed from 2/27/24 through and Rehab Center was	E	TITLE		(X6) DATE		
	Van Voorst			Administra	ator	3/19/24		

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether ocnot 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.

MAR 1 9 2024

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South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ 02/28/2024 B. WING 80076 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1065 MONTGOMERY ST **CUSTER CARE AND REHAB CENTER** CUSTER, SD 57730 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/24 through 2/28/24. Custer Care and Rehab Center was found in compliance.

Samuel Van Voorst

Administrator

TITLE

(X6) DATE

3/19/24

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