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

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF AND PLAN OF	CORR	ICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		V) 15	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			43	3401	B. WING_			11/	11/13/2024	
		R OR SUPPLIER	NTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 OAK STREET POST OFFICE BOX 100 FAULKTON, SD 57438				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PREFIX TAG	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
J 000	INIT	IAL COMMEN	rs		10	00				
	A recertification health survey for compliance with 42 CFR Part 491, Subpart A, requirements for rural health clinics, was conducted on 11/13/24. Faulkton Area Medical Center was found in compliance.									
LABORATORY	DIREC	TOP'S OF PROVIDE	ER/SUPPLIER REPRES	ENTATIVE'S SIGNATUR	DE .		TITLE		(X6) DATE	

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 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.

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

Event ID: ZRYG11

Facility ID: 11141

CEO/Administrator

If continuation sheet Page 1 of 1

11/19/2024

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STATEMENT OF DEF AND PLAN OF CORF			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			433401	B. WING_		11/13/2024	
		R OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 OAK STREET POST OFFICE BOX 100 FAULKTON, SD 57438			
(X4) ID PREFIX TAG		(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
E 000	A re	Part 491.12, S paredness requises, was conduc	vey for compliance with 42 subpart A, Emergency frements for rural health ted on 11/13/24. Faulkton er was found in compliance.	EO	000		
ABORATORY I	DIRECT Bea	TOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	TITLE CEO/Administ	(X8) DATE	

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 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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