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

PRINTED: 07/17/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		433438					
NAME OF PROVIDER OR SUPPLIER BROOKINGS HEALTH SYSTEM VOLGA MEDICAL CLINIC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 KASAN AVENUE VOLGA, SD 57071			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
J 000	INITIAL COMMEN	TS	J 000				
	with 42 CFR Part 4 for rural health clin	ealth survey for compliance 491, Subpart A, requirements ics, was conducted on 7/11/23. System Volga Medical Clinic bliance.					
	-					Ta-r	
						040	
						GE	
						12.	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	
	Cannifer Chandler			Director of Clinical Services		7/17/2023	
Any deficiency other safeguard ollowing the da	statement ending with a ds provide sufficient prot ate of survey whether pr	n asterisk (*) denotes a deficiency which the insection to the patients. (See instructions.) Exce not a plan of correction is provided. For nursin	pt for nursing ho g homes, the ab	excused from correcting providing it is determined ones, the findings stated above are disclosable 90 bove findings and plans of correction are disclosable approved plan of correction is requisite to continu) days le 14	2	

SD DOH-OLC

program participation.

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

Event ID: QNYP11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	433438 B		B. WING _	-	07/11/2023	07/11/2023	
NAME OF PROVIDER OR SUPPLIER BROOKINGS HEALTH SYSTEM VOLGA MEDICAL CLINIC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 KASAN AVENUE VOLGA, SD 57071			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION	N	
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 491.12, Subpart A, Emergency Preparedness requirements for rural health clinics, was conducted on 7/11/23. Brookings Health System Volga Medical Clinic was found in compliance.		E 0	000			
	,						
ABORATORY D	IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE	_	
Jenn	rifer Chana	ller		Director of Clinical Service	7/17/2023	_	

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 projection to the patients (Sec instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not application 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 Versibns Obsolete

Event ID: QNYP11

Facility ID: 66554

If continuation sheet Page 1 of 1

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