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

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  ST MICHAEL'S HOSPITAL - CAH  ST MICHAEL'S HOSPITAL - CAH  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  410 W 16TH AVE  TYNDALL, SD 57066  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  CO			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE			431327	B. WING _			08/2	29/2024
TYNDALL, SD 57066    CAU   ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY   CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY   CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY   CROSS-REFERENCE	NAME OF PE	PROVIDER OR SUPPLIER						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (INITIAL COMMENTS  (C 000  INITIAL COMMENTS  C 000  A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals (CAH) and Long Term Care Services ("swing bed"), was conducted from 8/27/24 through 8/29/24. St Michael's Hospital CAH was found not in compliance with the following requirement: C1016.  C 1016  C 1016  C 1016  C 1016  C 1016  C 1016  C 1017  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1. On 8/28/2024, upon discovery of the key in the anesthesia cart the key was removed and placed in the procedure from lock box, which is locked in the hospital pharmacy. The bottle of sevoflurane was removed from the anesthesia cart and locked in the hospital pharmacy in the "procedure to the hospital pharmacy in the "procedure day RN removes this box on procedure day RN removes this box on procedure day RN removes this box on procedure day RN and the hospital pharmacist, on procedure day RN and the hospital pharmacist, on procedure days, to ensure the key is returned to the lock box in the hospital pharmacy. Access to the hospital	ST MICHA	AEL'S HOSPITAL - CAH						
C 000  INITIAL COMMENTS  A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals (CAH) and Long Term Care Services ("swing bed"), was conducted from 8/27/24 through 8/29/24. St Michael's Hospital - CAH was found not in compliance with the following requirement: C1016.  C1016	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.  This STANDARD is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure only authorized personnel had access to medications stored in two of two carts (anesthesia cart and medication cart) in one of one procedure room.  Findings include:  1. Observation and interview on 8/28/24 at 9:00 a.m. with material purchasing technician B in the procedure room revealed:  *The procedure room was open due to another surveyor completing survey tasks.  *The material purchasing technician was asked if the red tool chest was used for medication	C1016	A recertification healt with 42 CFR Part 485 485.605-485.645, rec Access Hospitals (CA Services ("swing bed" 8/27/24 through 8/29/CAH was found not in following requirements PATIENT CARE POL CFR(s): 485.635(a)(3 [The policies include (iv) Rules for the storand administration of These rules must prostorage area that is a with accepted profess and accurate records disposition of all scheoutdated, mislabeled, drugs are not availab This STANDARD is a Based on observation review, the provider from authorized personnel stored in two of two of medication cart) in or Findings include:  1. Observation and in a.m. with material purpocedure room reversurely recompleting at the red tool chest was a services.	th survey for compliance of Subpart F, Subsections quirements for Critical (AH) and Long Term Care (T), was conducted from (Z4. St Michael's Hospital - In compliance with the ct. C1016.  ICIES (B)(iv)  the following:]  rage, handling, dispensation, drugs and biologicals.  vide that there is a drug administered in accordance sional principles, that current is are kept of the receipt and eduled drugs, and that it, or otherwise unusable alle for patient use.  Interview, and policy failed to ensure only thad access to medications carts (anesthesia cart and the of one procedure room.  Interview on 8/28/24 at 9:00 richasing technician B in the saled:  In was open due to another survey tasks.  Ising technician was asked if is used for medication	C10	key in the anesthesia removed and placed in room lock box, which in hospital pharmacy. The sevoflurane was removed anesthesia cart and lomedication cart.  2. A process has been the key to the medication by the pharmacy in the procedure day in the medication cart key from the procedure day in the proced	cart the key on the proceed is locked in the selected to not the control of the c	maintain he red in the cabinet. his box re nurse ored by spital ensure in the hospital nacist le is access the box. will be sists by be and ember ed or key	
BADONI ON DIRECTORS ON NOVIDENCE PER NEW RESERVANCE			SUPPLIER REPRESENTATIVE'S SIGNATURE					(X6) DATE 9/12/2024

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: 3RYC11

SFP 1 9 2024

SD DC-rI-OLC

Facility ID: 10568

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

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

				B) DATE SURVEY COMPLETED			
		431327	B. WING		08.	/29/2024	
100 mm = 3+0.01.1	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 W 16TH AVE TYNDALL, SD 57066				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
C1016	storage. *She then opened the drawer and removed plastic cup. *She then opened the cart) located next to ti *The certified nurse a medication cart key in drawer. *Certified nursing ass maintenance had acc *She was not aware s should not have acce *The procedure room punch key lock which Observation on 8/28/2 procedure room confi *In the anesthesia car sevoflurane (a volatile hypnosis, amnesia, a procedures). *The medication cart medications inside of -Xylocaine 20 millilite -Normal saline 0.9 per flushesNitroglycerin 0.4 milli -Ondansetron 4 mg/2 -Glycopyrrolate 0.2 m	e unlocked anesthesia cart a set of keys stored in a  a red tool chest (medication the anesthesia machine. Inesthetist stored the a the anesthesia machine I istants, housekeeping, and the ses to the procedure room. The above listed staff the ses to medications. I door was secured with a was the normal practice.  A at 9:00 a.m. in the the anesthetic that provides and analgesia during surgical thad the following it: I (ml) one vial. I (mcent (%) six syringe I igrams (mg) tabs one vial. I in one vial. I mg/ml one ampule. I mg/ml one ampule. I mg/ml one ampule. I mg/ml one vial. I one vial.	C1016	3. As a result of the process che there are several QAPI measur. The first is the QAPI measure, times the key was appropriately the hospital pharmacy in the proom lock box. A second QAPI measurement is also checking sevoflurane is located in the loc medication cart pre and post proday. Measurement for both of the measures will occur monthly ducontrolled substance inventory on procedure days. Data will be monthly to the quality committe DON until the QAPI has been 1 continuous months. Additional includes dashboard review with medical staff and hospital board directors.	ements. percent of a locked in ocedure that the sked ocedure nese uring the check and reported by the 00% for 6 oversight the	10/7/2024	

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

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		0.0000000000000000000000000000000000000	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		431327	B. WING_		08/29/2024	
NAME OF PROVIDER OR SUPPLIER  ST MICHAEL'S HOSPITAL - CAH				STREET ADDRESS, CITY, STATE, ZIP CODE 410 W 16TH AVE TYNDALL, SD 57066		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
C1016	-Epinephrine 1 mg/ml -Flumazenil 0.5 mg/5 -Bupivacaine 0.25% 1 Interview on 8/28/24 a nursing (DON) A and *The keys to the med been stored in the uni *Medications stored in have been accessible and should have been *The DON and pharm anesthetist had his ov *A secure place to sto medication keys woul  Interview and review with pharmacy manag November 2023 Medi Pharmacy policy conf *All areas where med have been locked at a *The policy had not as should not have been individuals. *She was not aware to a set of keys. *The keys to the medi been stored in the uni safety reasons. *Medications stored in would have been accession.	one vial. ml one vial. 10 ml one vial. at 9:15 a.m. with director of pharmacist C confirmed: ication cart should not have locked anesthesia cart. In the procedure room would to unauthorized personnel in securely stored. Itacist C were not aware the lown set of keys. In the anesthesia dineed to be determined. In 8/29/24 at 12:16 p.m. In the provider's cations Located Outside the limed: ications were stored should	C10	16		

PRINTED: 09/05/2024 **FORM APPROVED** South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 48584 08/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 W 16TH AVE ST MICHAEL'S HOSPITAL TYNDALL, SD 57066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 1. St. Michael's has revised their admission 10/7/2024 S 000 Compliance/Noncompliance Statement S 000 packet with the missing components from the administrative rule, 44:75:15:03, A licensure survey for compliance with the including the required admission Administrative Rules of South Dakota, Article agreement signature form. These revised 44:75, Hospital, Specialized Hospital, and Critical packets and the agreement form were put into effect with admissions on or after Access Hospital Facilities, was conducted from 8/27/24 through 8/29/24. St. Michael's Hospital was found not in compliance with S433. 2. The Health Unit Coordinator will review every swing bed admission for a proper S 433 44:75:15:03 Facility to Provide Information-Adm S 433 signed and dated admission agreement that includes subdivisions (1) to (8) Agreement between the patient/legal representative and St. Michael's Hospital Avera. A signed and dated admission agreement Education on this process change will be between the patient or the patient's legal provided to nurses and health unit representative and the facility shall include coordinators by October 7, 2024. Education subdivisions (1) to (8), inclusive, of this section. will be monitored by the DON. The patient or patient's legal representative and 3. The QAPI data, percentage of admission the facility shall complete the admission agreements signed/dated, will be reported agreement before or at the time of admission and monthly by the DON on the QAPI before the patient has made a commitment for dashboard to the quality committee until the payment for proposed or actual care. The QAPI has been 100% for 6 continuous agreement may not include ambiguous or months. Additional oversight includes dashboard review with the medical staff a misleading information and may not be in conflict with this chapter. The agreement shall be printed nd hospital board of directors. for ease of reading by the patient. If the agreement exceeds three pages, it shall contain a table of contents or an index of principal sections. Any change in the information shall be given to the patient or the patient's legal representative as a signed and dated addendum to the original agreement. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, Swing Bed

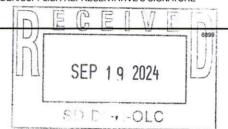
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

for those services.

Program Information sheet review, and hospital admission packet review, the provider failed to ensure five of five (1, 2, 3, 4, and 5) sampled swing bed patients had received information on: \*Services available in the facility and the charges

Ashli Danilko

STATE FORM



TITLE

(X6) DATE

CEO

9/12/2024

TMQG11

South Dakota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			-			
		48584	B. WING		08/29/2024	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST MICHA	EL'S HOSPITAL	410 W 16T	H AVE			
OT MILOTIA	ELOHOOFITAL	TYNDALL	SD 57066			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 433	Continued From page	21	S 433			
S 433	*Services offered for have been charged a would have been charged a would have been charged a How patients can pro 'How to apply for and 'The address and telenearest United States Administration office. 'The provider's bed-held, and readmission 'The responsibilities of medications. 'The availability of su correction upon requesting include:  1. Review of patients' record revealed the irnot included within the 'The signed Consent medical record for pa 'The Swing Bed Progprovided to patients we'the hospital admission in the supon admission th	which the patient may not nd services the patient rged. Detect their personal funds. I use Medicare. Dephone number for the social Security  Hold policy, length of time in rights. For self-administration of revey results and plan of est.  1, 2, 3, 4, and 5's medical information listed above was defollowing documents: - Admission form in the tients 1, 2, 3, 4, and 5.  For am Information sheet when admitted to swing bed. For the Administrative Rules 5:15.03 (S433) on 8/29/24 dector of nursing A confirmed wing bed patients had not on: For evices and charges. For evices and charg	S 433			
	*The provider's bed hold policyThe provider had not done bed holds in the past, but there was a potential they could. *The availability of survey results upon request.					

PRINTED: 09/05/2024 FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING\_ 48584 08/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 W 16TH AVE ST MICHAEL'S HOSPITAL TYNDALL, SD 57066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/05/2024 FORM APPROVED

DEFAITIVIENT OF TIEALTH	AND HOWAN SERVICES		FORW APPROVEL
CENTERS FOR MEDICARE	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	431327	B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER

ST MICHAEL'S HOSPITAL - CAH

STREET ADDRESS, CITY, STATE, ZIP CODE

410 W 16TH AVE

T MICHA	EL'S HOSPITAL - CAH	T	TYNDALL, SD 57066			
(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		
E 000	Initial Comments	E 000				
	A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted on 8/27/24. St. Michael's Hopsital - Cah was found in compliance.					

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

TITLE

(X6) DATE

Ashli Danilko

CEO

9/12/2024

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 plathof 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

SEP 1 3 2024 Event ID: 3RYC21

SD D -- OLC

Facility ID: 10568

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		N 20	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - ST. MICHAEALS HOSPITAL				
		431327	B. WING		08/27/2024			
	ROVIDER OR SUPPLIER		410	REET ADDRESS, CITY, STATE, ZIP CODE 0 W 16TH AVE 'NDALL, SD 57066				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 000	8/27/24 for compliant (1), requirements for	ey was conducted on ce with 42CFR 485.623(d) critical access hospitals. St. Cah (Bldg 01) was found in	K 000					
ABODATODY		SUPPLIER REPRESENTATIVE'S SIGNATUI		TITLE	(VA) PATE			
Ashli Dar		BUFFLIER REPRESENTATIVE'S SIGNATUL	NE.	CEO	9/12/2024			

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 10:3RYC2 SEP 1 3F20240: 10568

SD DC-1-OLC

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ST. MICHAELS HOSPITAL			(X3) DATE SURVEY COMPLETED		
		431327	B. WING_	B. WING			27/2024
	NAME OF PROVIDER OR SUPPLIER  ST MICHAEL'S HOSPITAL - CAH			4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 W 16TH AVE YNDALL, SD 57066		
(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
K 000	A recertification surve		K	000			
	(1), requirements for (	critical access hospitals. St. cah (Bldg 02) was found in					
-							
Ashli Dan	ilko	UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE CEO	9	X6) DATE /12/2024

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: 3RYC21

SD DCH-OLC

Facility ID: 10568

## 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:	8 8		PLE CONSTRUCTION G 03 - ST. MICHAELS HOSPITAL		(X3) DATE SURVEY COMPLETED	
431327 B. WING				08/27/2024				
	ROVIDER OR SUPPLIER		•	410 \	EET ADDRESS, CITY, STATE, ZIP CODE W 16TH AVE DALL, SD 57066			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 000	8/27/24 for compliant (1), requirements for	ey was conducted on ce with 42CFR 485.623(d) critical access hospitals. St. Cah (Bldg 03) was found in	K	000				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE CEO	12	(X6) DATE	
Ashli Dar	nilko				CEO	ç	9/12/2024	

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

1 3 2024 Event ID: 3RYC2

SO DO --- OLC

Facility ID: 10568