PRINTED: 07/09/2025 FORM APPROVED

OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE 300 22nd Ave , BROOKINGS, South Dakota, 57006 [X4] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG RESULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS INITIAL COMMENTS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPL IDENTIFICATION NUMB 431509			A	(10)		(X3) DATE SURVE 06/25/2025	(3) DATE SURVEY COMPLETED 6/25/2025	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L0000 INITIAL COMMENTS A recertification survey for compliance with 42 CFR Part 418, Subparts C-D, requirements for hospice, was conducted from 6/23/25 through 6/25/25. Brookings									
A recertification survey for compliance with 42 CFR Part 418, Subparts C-D, requirements for hospice, was conducted from 6/23/25 through 6/25/25. Brookings	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE		COMPLETION	
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other		A recertification survey for co Part 418, Subparts C-D, requ conducted from 6/23/25 throu Hospital Hospice was found in	irements for hospice, was igh 6/25/25. Brookings in compliance.						

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

Jason Merkley

President & CEO

(X6) DATE July 11, 2025

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	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 431509			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025			
NAME OF PROVIDER OR SUPPLIER Brookings Hospital Hospice				STREET ADDRESS, CITY, STATE, ZIP CODE 300 22nd Ave , BROOKINGS, South Dakota, 57006					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
E0000	Initial Comments A recertification survey for copart 418, Subpart B, Subsec Preparedness, requirements from 6/23/25 through 6/25/25 Hospice was found in compliance.	tion 484.113 Emergency for hospice, was conducted . Brookings Hospital	E	0000					

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.

President & CEO

(X6) DATE

July 11, 2025