CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2024 **FORM APPROVED** 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	
-9		431320	B. WING _			06/	05/2024
	ROVIDER OR SUPPLIER	WOOD HOSPITAL		61	CHARLES STREET EADWOOD, SD 57732		5 (53 5 (54 5 (54
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	N	ΕC	000			
E 039	CFR Part 485, Subpatemergency Prepared Critical Access Hospir June 4, 2024 through Health Lead-Deadwo compliance. The building will meet 2012 LSC for existing upon correction of the E039 in conjunction vicommitment to continusafety standards. EP Testing Requiremer CFR(s): 485.625(d)(2) §416.54(d)(2), §418.1 §460.84(d)(2), §482.1 §483.475(d)(2), §484.1 §485.542(d)(2), §485.1 *[For ASCs at §416.5 at §485.727, CMHCs at §491.12, and ESRD Fertility (2) Testing. The [facility to test the emergency must do all of the following community-based every community-based every community-based every complex complex community-based every complex	ued compliance with the fire ents) 13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs organizations" under §485.920, RHCs/FQHCs at facilities at §494.62]: ty] must conduct exercises or plan annually. The [facility] owing: escale exercise that is ery 2 years; or	EC	039	Reviewed Drill/Event with Presider 6/21/2024, Reviewed EOP for education for critical access hospital requirements. 2024 drills will be table top exercis August 20th, 2024 will be lost hike. Actual mass casualty will be during month of October 2024. 2 exercises were completed in 202 which were actual events EOP supervisor did not load in HICS for recording. Events were: 1) 9/14/2023 tour bus stopped at E surge event as several showed sig of covid. Events were debriefed an recorded. 60 bus riders. 2)Winter ice storm- condition snow staff plan and concern for accident 12/25-26, 2023. EOP Supervisor will report drills president will review for documents and completion.	ED gns and vtts	6/24/2024
	(A) When a commun	ity-based exercise is not facility-based functional			and completion.	,	eā.
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE President		(X6) DATE 24/2024

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 Ods

JUN 2 4 2024D: RFM 2

SD DOH-OLC

Facility ID: 10535

If continuation sheet Page 1 of 10

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		431320	B. WING _			06/0	05/2024
i	ROVIDER OR SUPPLIER NT HEALTH LEAD-DEAD	WOOD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732			11v	
. (X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO		ACTION SHOULD B TO THE APPROPRIA		(X5) COMPLETION DATE
E 039	natural or man-made activation of the eme exempt from engagin community-based or functional exercise for actual event. (ii) Conduct an additivers, opposite the years, opposite y	experiences an actual emergency that requires regency plan, the [facility] is g in its next required individual, facility-based Illowing the onset of the conal exercise at least every 2 ear the full-scale or or order paragraph (d)(2)(i) of order, that may include, but is wing: The exercise that is individual, facility-based or exercise that is individual, facility-based or exercise that is led by des a group discussion using relevant emergency of problem statements, for prepared questions ean emergency plan. The exercise that is end in order and revise the plan, as needed. The exercise that is exercise that is emergency plan at least the must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not an individual facility based	EC	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	431320 B. WING		06/05/2024		
2000 V 20	ROVIDER OR SUPPLIER	WOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
E 039	man-made emergency plan, the emergency plan, the emergency plan, the engaging in its next recommunity-based exercises of the emergency of the emergency of the emergency of the emergency of the exercise under paraging is conducted, that mate to the following: (A) A second full-scally-based or a exercise; or (B) A mock disaster of the exercise and include a narrated, clinically-rescenario, and a set of directed messages, of designed to challenges (3) Testing for hospice care directly. The hospice receives to test the eyear. The hospice music community-based; of the emergency plan, the emergency of	y that requires activation of the hospital is exempt from equired full scale ercise or individual all exercise following the cy event. In all exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited as facility based functional exercise that is a facility based functional every event. In all exercise every 2 years, full-scale or functional exercise that is a facility based functional every exercise that is a facility based functional event emergency problem statements, or prepared questions an emergency plan. In the provide inpatient exercise must conduct exercise in the provide inpatient exercise is not annual full-scale exercise is not annual individual all exercise; or exiences a natural or annual full-scale community of functional exercise	E	039	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
5		431320	B. WING		06/05/2024		
#S	ROVIDER OR SUPPLIER NT HEALTH LEAD-DE	ADWOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	may include, but is (A) A second full-scommunity-based exercise; or (B) A mock disaste (C) A tabletop exercise; and a set of proble messages, or prepichallenge an emericiii) Analyze the homaintain document exercises, and emercises, and emercises, and emercises, and emercises and em	not limited to the following: scale exercise that is or a facility based functional er drill; or recise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. espice's response to and tation of all drills, tabletop ergency events and revise the ecy plan, as needed. 41.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must an annual full-scale exercise that ed; or unity-based exercise is not ext an annual individual, itonal exercise; or ospital, CAH] experiences an an-made emergency plan, the from engaging in its next community based or individual, itonal exercise following the	E 039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		431320	B. WING _		06/05/2024
	ROVIDER OR SUPPLIER NT HEALTH LEAD-DEAL	OWOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
E 039	functional exercise; of (B) A mock (C) A tabletop excled by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the [maintain documentat exercises, and emerge [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE (E) (E) (E) (E) (E) (E) (E) (E) (E) (E	alle exercise that is individual, a facility-based or disaster drill; or ercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed.	EO	39	5 - 55 - 55 - 55 - 55 - 55 - 55 - 55 -
	annually. The PACE of following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experiment and emergency plan, engaging in its next rebased or individual, factorise following the event. (ii) Conduct an anyears opposite the ye exercise under parage	ty-based exercise is not n annual individual,			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
e:		431320	B. WING _		06/05/2024		
*	ROVIDER OR SUPPLIER	ADWOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732		. 11	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 039	community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator and inclusing a narrated, cl scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain document exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency proced ICF/IID] must do th (i) Participate in an is community-base (A) When a community-based function (B) If the [LTC facility actual natural or marequires activation LTC facility is exem required a full-scale individual, facility-b following the onset (ii) Conduct an add may include, but is (A) A second full-si	cale exercise that is or individual, a facility based or a drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. ACE's response to and ation of all drills, tabletop ergency events and revise the plan, as needed. at §483.73(d):] If must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: a annual full-scale exercise that d; or unity-based exercise is not an annual individual, ional exercise. Ity] facility experiences an an-made emergency plan, the opt from engaging its next ecommunity-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: ional exercise that is or an individual, facility based	EC	039			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		431320	B. WING _		06/05/2024
	ROVIDER OR SUPPLIER	WOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
E 039	(B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-releand a set of problems messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's exercises, and emerge [LTC facility] facility's exercises. The ICF/IIDs at §483 (2) Testing. The ICF/IID must dott (i) Participate in an an is community-based; of (A) When a community accessible, conduct an facility-based functional (B) If the ICF/IID expe man-made emergency plan, the emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster dr (C) A tabletop exercises a facilitator and included a	drill; or see or workshop that is led by group discussion, using a sevant emergency scenario, statements, directed discontations designed to not plan. It is a sevent emergency scenario, statements, directed discontation of all drills, tabletop ency events, and revise the emergency plan, as needed. 1.475(d)]: Discontant conduct exercises plan at least twice per year. The following: In the	EOS	39	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		431320	B. WING			06/	05/2024
	ROVIDER OR SUPPLIER	DWOOD HOSPITAL		61 (REET ADDRESS, CITY, STATE, ZIP CODE CHARLES STREET ADWOOD, SD 57732		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	directed messages, of designed to challeng (iii) Analyze the ICF/I maintain documentate exercises, and emergic ICF/IID's emergency *[For HHAs at §484.' (d)(2) Testing. The H to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a community-based function or. (B) If the HHA end or man-made emergency of the emergency plangaging in its next in community-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paraging is conducted, that is intended to the following (A) A second full community-based or functional exercise; of (B) A mock disart (C) A tabletop exiled by a facilitator and discussion, using a remergency scenario	or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. IO2] HA must conduct exercises y plan at IHA must do the following: I-scale exercise that is munity-based exercise is not an annual individual, hal exercise every 2 years; experiences an actual natural ency that requires activation an, the HHA is exempt from required full-scale individual, facility based ollowing the onset of the onal exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section at may include, but is not ag: I-scale exercise that is an individual, facility-based or ster drill; or exercise or workshop that is	Е	039			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		431320	B. WING		06/05/2024	
	ROVIDER OR SUPPLIER	WOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
E 039	plan. (iii) Analyze the HHA' documentation of all of emergency events, an emergency plan, as n *[For OPOs at §486.3] (d)(2) Testing. The Oil to test the emergency following: (i) Conduct a paper-b workshop at least ann led by a facilitator and discussion, using a na emergency scenario, statements, directed of questions designed to plan. If the OPO exper man-made emergency the emergency plan, engaging in its next re following the onset of (ii) Analyze the OPO's documentation of all to	s response to and maintain drills, tabletop exercises, and and revise the HHA's leeded. 660] PO must conduct exercises or plan. The OPO must do the ased, tabletop exercise or mustly. A tabletop exercise is dincludes a group exercised, clinically relevant and a set of problem messages, or prepared or challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. It is response to and maintain abletop exercises, and and revise the [RNHCI's and	E 03	9		
	*[RNCHIs at §403.74 (d)(2) Testing. The RI exercises to test the emust do the following (i) Conduct a paper-bleast annually. A table discussion led by a faclinically-relevant emoof problem statement	.8]: NHCI must conduct emergency plan. The RNHCI				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	54 12.	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		431320	B. WING _		06/	05/2024	
	ROVIDER OR SUPPLIER	DWOOD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
E 039	and emergency ever emergency plan, as This STANDARD is Based on record rev provider failed to cor emergency prepared include: 1. Record review on no documentation at test the emergency preserved.	CI's response to and tion of all tabletop exercises, ats, and revise the RNHCI's needed. not met as evidenced by: view and interview, the aduct an exercise for liness in 2023. Findings	EO	39			
	6/5/24 at 7:30 a.m. a	and the ambulance supervisor in. confirmed that finding.					

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PRINTED: 06/17/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	255 155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		431320	B. WING			06/05/2024		
	ROVIDER OR SUPPLIER NT HEALTH LEAD-DEAD	WOOD HOSPITAL		6	TREET ADDRESS, CITY, STATE, ZIP CODE 1 CHARLES STREET DEADWOOD, SD 57732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	ey for compliance with the	K	000				
	Life Safety Code (LSI occupancy) was cond Health Lead-Deadwo compliance with 42 C requirements for Criti The building will mee 2012 LSC for existing and the Fire Safety E	C) (2012 existing health care ducted on 6/4/24. Regional od Hospital was found not in FR 485.623 (d)(1)					2 (27) 2 (25) 2 (25) 2 (25) 2 (25) 2 (25)	
K 161	to correct the deficien K324, and K363 in co	ciencies identified as indicate the provider's intent acies identified at K293, onjunction with the provider's aued compliance with the fire	к	161			F	
		type and stories meets s otherwise permitted by						
	Construction 1 I (442), I (33 stories sprinklered	2), II (222) Any number of non-sprinklered and						
	2 II (111)	One story					202 /202 5. /202	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	e.	(X6) DATE	

Mark C. Schmidt

President

6/21/2024

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.

Even ID:RFM721

FORM CMS-2567(02-99) Previous Versions

JUN 2 4 2024

SD DOH-OLC

Facility ID: 10535

If continuation sheet Page 1 of 9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			March March		CONSTRUCTION - MAIN BUILDING	(X3) DATE SURVEY COMPLETED	
*1		431320	B. WING			06/	05/2024
***************************************	ROVIDER OR SUPPLIER	DWOOD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	250.0	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 161	system in accordance 19.3.5) Give a brief descript construction, the nut basements, floors of location of smoke of approval. Complete plan of the building at This STANDARD is Based on observation review, the provider construction standar Code (LSC) (incomposystem installation). 1. Observation on 6 the building was a thron-combustible, Tycomplete automatic	Not allowed Maximum 2 stories Not allowed Maximum 1 story Must be sprinklered proved, supervised automatic be with section 9.7. (See Jon, in REMARKS, of the mber of stories, including must be arriers and dates of sketch or attach small floor as appropriate. Inot met as evidenced by: Jon, interview, and document failed to meet the minimum ands of the 2012 Life Safety Jolete NFPA 13 sprinkler Findings include: Jolete NFPA 13 sprinkler Findings include: Jolete NFPA 13 sprinkler Jolete NF	К	161			

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 200000000000000000000000000000000000	LE CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED	
		431320	B. WING		06/05/2024	
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION	
K 161	The facility meets the system (FSES). Pleas completion date colur	urvey documents dated above condition.	K 16	1	2	
K 225	CFR(s): NFPA 101 Stairways and Smoke	eproof Enclosures eproof enclosures used as se with 7.2.	K 225	5	F	
	Based on observation review, the provider farexit stairways in five recount stairs, northwestairs, and the north stairs, and the north stairwell in the south st	not met as evidenced by: n, interview, and document ailed to maintain conforming andomly observed locations at stairs, east stairs, west tairs). Findings include: //24 at 11:15 a.m. revealed ovided on both sides of the stairs and at the top of the est stairs. The south stairs The northwest stairs were //24 at 2:30 p.m. revealed front of the exterior exit door oved up approximately six eshold.			日 日 日 日 日 日 日 日 日 日 日 日 日 日 日 日 日 日 日	

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND DI AN OF CORRECTION IN IMPER-		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING (X3) DATE COMP			
*	431320 B. W	NG		06/05/2024	
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH LEAD-DEADWOOD HOSPI	TAL	STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732			
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PRECI TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL P		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
3. Observation on 6/4/24 between 2 3:00 p.m. revealed the following do into stair enclosures reduced the lat to less than 22 inches: * The door opening into the first floor reduced the landing to 15 inches. * The door opening into the first floor reduced the landing to 19 inches. * The door opening into the first floor reduced the landing to 19 inches. * The door opening into the first floor reduced the landing to 17 1/2 inches. 4. Interview with the director of plant the time of the above observations those findings. Review of previous documents dated 7/8/19 confirmed findings. The facility meets the fire safety evisystem (FSES). Please mark an "F completion date column to indicate intent to correct the deficiencies ide K000. K 293 Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displated accordance with 7.10 with continuous also served by the emergency light 19.2.10.1 (Indicate N/A in one-story existing of with less than 30 occupants where travel is obvious.) This STANDARD is not met as evidence in the connecting link from locations in the connecting link from	or openings Inding widths or, east stairs or, west stairs or, north stair	revieve sign version v	dentified in cooridor was wed and illuminated exit was installed with battery up along with magnetic stres were removed to deactive agnetic devise. Was com 4 by maintenace staff and wed by supervisor for oletion.	vate pleted	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2024 -FORM APPROVED . OMB NO. 0938-0391 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING 01 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		431320	B. WING		06/0	05/2024	
	ROVIDER OR SUPPLIER NT HEALTH LEAD-DEAD	DWOOD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 293	to the clinic. The continuous also magnetically 1. Observation on 6/4 exterior door from the hospital to the clinic. for the connecting link also magnetically lock egress feature or according the connecting link. Interview with the plattime of the observation The deficiency affects be provided with a magnetic extension of the observation of the observation of the cooking Facilities (Cooking Facilities (Cooking Facilities (Cooking Experiment is with NFPA 96, Standard Fire Protection of the observation of the observatio	necting link exterior door y locked. Findings include: 4/24 at 9:45 a.m. revealed an a connecting link for the There was no marked exit k. The exterior door was ked without a delayed ress-controlled feature to exit and operations manager at the con confirmed those findings. The exterior door was ked without a delayed ress-controlled feature to exit and operations manager at the con confirmed those findings. The exterior door was ked without a delayed ress-controlled feature to exit and operations manager at the conconfirmed those findings. The exterior door was ked without a delayed ress-controlled feature to exit and operations manager at the conconfirmed those findings. The exterior door was ked without a delayed ressertion of the exit of the exit of the control of the exterior of the exterior door in smoke the compartments with comply with conditions under	K 293		eventive -annual ne cleaing one	6/19/202	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED			
		431320	B. WNG_			06/0	05/2024	
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 324	corridor. 18.3.2.5.1 through 18.19.3.2.5.5, 9.2.3, TIA This STANDARD is Based on record rev provider failed to consix-month inspection	not met as evidenced by: view and interview, the iduct the required every of the facility's cooking stem for the range hood for	K	324				
K 351	grease build-up in 20 Interview with the pla 6/4/24 at 1:00 p.m. re the ductwork inspect The deficiency affect kitchen range hood a Sprinkler System - In CFR(s): NFPA 101 Spinkler System - In 2012 EXISTING Nursing homes, and construction type, ar approved automatic accordance with NFI Installation of Sprink In Type I and II cons	itchen hood exhaust inspected for cleanliness and 123. ant operations manager on evealed he was unaware of ion requirements. Ited the requirements for the and exhaust system. Installation Install	к	351			F	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 20	PLE CONSTRUCTION IG 01 - MAIN BUILDING	COMPLETED
		431320	B. WING _		06/05/2024
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732	10. (c)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 351	sprinkler protection in or local regulations p In hospitals, sprinkler closets of patient slee of the closet does not sprinkler coverage corequired by NFPA 13 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.19.4.2, 19.3.5.10, 9.7 This STANDARD is a Based on observation review, the provider from the construction standard.	a specific areas where state rohibit sprinklers. It is are not required in clothes eping rooms where the area at exceed 6 square feet and overs the closet footprint as a standard for Installation of 1.3.5.3, 19.3.5.4, 19.3.5.5, 19.7.1.1(1) and met as evidenced by: In, interview, and document ailed to meet the minimum als of the 2012 Life Safety ete NFPA 13 sprinkler	КЗ	51	
	the building was a thr non-combustible, Typ complete automatic s Interview with the pla time of the observation Review of previous st 7/18/19 confirmed the The facility meets the system (FSES). Plea completion date colum	ne II (111) structure without a sprinkler system. Introperations director at the conconfirmed that finding. Introperations director at the conconfirmed that finding. Introduction that finding is above findings.		Cooridor door identifed had ch	air
K 363	CFR(s): NFPA 101 Corridor - Doors	idor openings in other than	К3		th 6/5/2024 liminates at safety pleted

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
*		431320	B. WING		06	/05/2024	
(九	PROVIDER OR SUPPLIER	EADWOOD HOSPITAL	61 CF	EET ADDRESS, CITY, STATE, ZIP CODE HARLES STREET IDWOOD, SD 57732	5		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 363	required enclosure hazardous areas in and are made of 1 wood or other mate at least 20 minutes smoke compartme the passage of sm to rooms containin materials have poslatches are prohibi requirements do not contain flam Clearance between covering is not excomplying with 7.2 with a device capa when a force of 5 limpediment to the devices that releas pulled are permitted of unlimited height meeting 19.3.6.3.6 shall be labeled are materials in complismoke compartme window assemblie sprinklered comparestrictions in area frames in window as 19.3.6.3, 42 CFR Fland 485 Show in REMARK protection ratings, etc. This STANDARD Based on observatiled to maintain in	resist the passage of smoke if 3/4 inch solid-bonded core sterial capable of resisting fire for its. Doors in fully sprinklered ents are only required to resist moke. Corridor doors and doors ing flammable or combustible sitive latching hardware. Roller ited by CMS regulation. These is to apply to auxiliary spaces that immable or combustible material. In bottom of door and floor deeding 1 inch. Powered doors 2.1.9 are permissible if provided able of keeping the door closed libf is applied. There is no closing of the doors. Hold open se when the door is pushed or its are permitted. Dutch doors are permitted. Door frames are permitted. Door frames are permitted. Door frames and made of steel or other liance with 8.3, unless the interest is sprinklered. Fixed fire its are allowed per 8.3. In artments there are no are or fire resistance of glass or	K 363			ī	

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		8 8	NG 01 - MAIN BUILDING	COMPLETED	
		431320	B. WING _		06/05/2024
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 61 CHARLES STREET DEADWOOD, SD 57732	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
K 363	Observation on 6/4 the corridor door to the corridor door to the was held open with a prevent the door from a fire emergency. Interview with the plattime of the observation. The deficiency had the corrections of the control of the corrections of the corrections.	e 8 dired. Findings include: 4/24 at 9:30 a.m. revealed the library on the second floor a chair. The chair could to being closed in the event of ant operations manager at the conconfirmed that finding. The potential to affect 100% of smoke compartment.	K3	363	

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If continuation sheet Page 1 of 1

	OT OIL WEDIONILE W	MEDICAID SERVICES			OND NO. 0930-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2. 2.	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		431320	B. WING		00/00/0004
NAME OF PE	ROVIDER OR SUPPLIER	401020		STREET ADDRESS, CITY, STATE, ZIP CODE	06/06/2024
	NT HEALTH LEAD-DEAD	DWOOD HOSPITAL		61 CHARLES STREET DEADWOOD, SD 57732	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
C 000	INITIAL COMMENTS	3	C	000	
	with 42 CFR Part 485 485.605-485.645, red Access Hospitals (CA				- 70 - 27 - 27 - 22 - 24 - 25 - 26 - 26
					17 15 16 16 16 16 16 16 16 16 16 16 16 16 16
Mark C Schn	nidt	SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE President	(X6) DATE 6/18/2024
other safeguard ollowing the da lays following t program partici	Is provide sufficient protection te of survey whether or not he date these documents an	on to the patients. (See Instructions.) Is a plan of correction is provided. For his remade available to the facility. If define	Except for nursin ursing homes, th ciencies are cited	be excused from correcting providing it is deter g homes, the findings stated above are disclosa e above findings and plans of correction are disc d, an approved plan of correction is requisite to c	ble 90 days closable 14

SD DOH-OLC

FORM APPROVED South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 06/06/2024 10535S NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **61 CHARLES ST** MONUMENT HEALTH LEAD-DEADWOOD HOSPITAL DEADWOOD, SD 57732 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 000 Compliance/Noncompliance Statement S 000 A licensure health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 6/4/24 through 6/6/24. Monument Health Lead-Deadwood Hospital was found in compliance.

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

TITLE President (X6) DATE

Mark C. Schmidt

QBVO11

6/18/2024

STATE FORM

6 JUN 2 4 2024 SD DOH-OLC If continuation sheet 1 of 1