DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/29/2024 FORM APPROVED

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 5	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		433427	B. WING			02/28/2024		
	ROVIDER OR SUPPLIER			100 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST SANBORN ST KER, SD 57053		П	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
E 000 Initial Comments A recertification survey for compliance CFR Part 491.12, Subpart A, Emergen		bpart A, Emergency	E	000				
	Preparedness require clinics, was conducte Medical Clinic was fo							
	-							
	×							
		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	
Any deficiency		sterisk (*) denotes a deficiency which the in	stitution ma	v be exc	CEO sused from correcting providing it is determined		2/29/2024	
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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 and plate 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

SD DOH-OLC

Even ID: D1X611

Facility ID: 433804

If continuation sheet Page 1 of 1

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Man Ax	TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER			B. WNG		02/28/2024		
	MEDICAL CLINIC			STREET ADDRESS, CITY, STATE, ZIP COD 100 EAST SANBORN ST PARKER, SD 57053	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
J 000	CFR Part 491, Subpa	ey for compliance with 42 art A, requirements for rural anducted on 2/28/24. Parker	J	000			
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	
indsey Hau			CEO		/29/2024		
ny deficiency ther safeguard llowing the da	statement ending with an as ds provide sufficient protection ate of survey whether or not	sterisk (*) denotes a deficiency which the i or let the patients it See instructions.) Exc a plan of correction is provided. For nursi re made available to the facility. If deficien	nstitution may cept for nursin ing homes, th	CEO y be excused from correcting providing it is d g homes, the findings stated above are disc e above findings and plans of correction are d, an approved plan of correction is requisite	letermined that losable 90 days disclosable 14	2312024	

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