DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2024 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			CIVID INC	J. 0938-039T	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Commence	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		433441	B. WING		02	/14/2024	
	ROVIDER OR SUPPLIER	CLINIC	415 9	STREET ADDRESS, CITY, STATE, ZIP CODE 415 9TH ST BRITTON, SD 57430			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
J 000	INITIAL COMMENTS A recertification survey for compliance with 42 CFR Part 491, Subpart A, requirements for rural health clinics, was conducted on 2/14/24. Marshall County Medical Clinic was found in compliance.		J 000				
LABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNATU	URE	TITLE CEO		(X6) DATE 2/26/24	

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. (Seeinstructions) 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: Q6BM11

SD DCH-OLC

Facility ID: 66884

If continuation sheet Page 1 of 1

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:	(X2) MULTIPLE A. BUILDING _	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
433441 B			B. WING	B. WING		
NAME OF PROVIDER OR SUPPLIER MARSHALL COUNTY MEDICAL CLINIC				STREET ADDRESS, CITY, STATE, ZIP CODE 415 9TH ST BRITTON, SD 57430		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 000	A recertification sun CFR Part 491.12, So Preparedness requir clinics, was conductor	vey for compliance with 42 ubpart A, Emergency rements for rural health ed on 2/14/24. Marshall ic was found in compliance.	E 000			
						(X6) DATE
_ABORATOR	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	CEO		
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institu						2/26/24

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.

SD DCH-OLC

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