PRINTED: 07/25/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 433439 B. WING 07/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 SOUTH JOHNSTON STREET WHITE LAKE MEDICAL CLINIC AVERA WHITE LAKE, SD 57383 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) J 000 **INITIAL COMMENTS** J 000 A recertification survey for compliance with 42 CFR Part 491, Subpart A, requirements for rural health clinics, was conducted on 7/19/23. White Lake Medical Clinic Avera was found in compliance. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Patti Nachtigal **Director of Clinical Operations** 7/25/23

Any deficiency statement ending with an asterisk (Tendes 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 RWK611

SD DOH-OLC

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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 (X2) MULTIF		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		433439	B. WING _		07/19/2023	
	ROVIDER OR SUPPLIER	/ERA		STREET ADDRESS, CITY, STATE, ZIP CODE 306 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DATE	
E 000	Initial Comments		EC	000		
	CFR Part 491.12, Su Preparedness require clinics, was conducte	ey for compliance with 42 bpart A, Emergency ements for rural health ed on 7/19/23. White Lake was found in compliance.				
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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Patti Nachtigal			RE	Director of Clinical Operation	(X6) DATE 7/25/23	

Facility ID: 66751