STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.608 - 485.645, requirements for Critical Care Hospitals (CAH) and Long Term Care Services (swing beds), was conducted from 8/21/23 through 8/23/23. Sanford Hospital Webster - CAH was found not in compliance with the following requirement: C914.	C 000		
C 914	MAINTENANCE CFR(s): 485.623(b) , 485.623(b)(1) The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and interview, the provider failed to follow the manufacturer's instructions and the policy for the safe storage of intravenous (IV) fluids in one of one fluid warming cabinet. Findings include: 1. Observation on 8/22/23 at 9:00 a.m. of the fluid warmer located in storage room 217 revealed: *The temperature on the fluid warmer was 110 degrees Fahrenheit (F). *There were two 1000 milliliter bags of 0.9 Sodium Chloride injection and two 1000 milliliter Lactated Ringers injection for patient use stored in the fluid warmer. Review of the Fluid Warmer Temperature Log from 8/1/23 through 8/22/23 revealed: *Temperatures were recorded twice per day by the nursing staff.	C 914	C914 Completion Date: 9/8/2023 1. Director of Nursing/Director of Nursing designee reset the fluid temperatures to 104 F on 8/22/2023. The two 1000 milliliter bags of 0.9 Sodium Chloride and two 1000 milliliter bags of Lactated Ringers were removed from the fluid warmer and discarded on 8/22/2023. 2. No adverse patient outcomes were noted for patients who received warmed fluids. 3. Director of Nursing reset the fluid temperature on 8/22/2023 to comply with the fluid warmer policy and a note was placed on the fluid warmer not to adjust the temperature from 104 F. Nursing staff was immediately re-educated on 8/22/23 that the fluid warmer temperature is not to exceed 104F by the Director of Nursing/ Director of Nursing designee with additonal education provided on 9/21/23. Nursing staff will continue to monitor the fluid warmer temperatures twice a day to ensure continued compliance of not exceeding 104 degrees F. 4. Beginning 9/8/2023, the Director of Nursing/Director of Nursing Designee will complete audits monitoring the temperature log completion. Audits will be completed daily for one week, then monthly for two months. Audit results will be brought to the Quality Assurance and Performance Improvement Committee for further recommendations.	9/8/23 IL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anna Morey | TITLE: CEO | (X6) DATE: 9/8/23

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.

RECEIVED SEP 12 2023 DEH-OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 914	Continued From page 1 *Every temperature recorded was 110 degrees F. Review of the 6/29/20 provider policy "Warmers for Fluids Irrigations and Blankets- Enterprise" revealed: *"Purpose: To provide guidelines for the storage conditions of intravenous solutions and /or irrigation solutions in fluid warmers." *"Policy: Fluid Warmers- When the use of warmed IV [intravenous] solutions and/or irrigating solutions is clinically indicated, medically necessary or desirable, the manufacturer's storage recommendations are followed (unless safety and efficacy outside manufacturer's recommendations have been documented with evidence-based guidelines)." *"Procedure: Fluid Warmers 1. Solutions for injection and irrigation should not come into direct contact with the heating element in the warmer. 2. Unless manufacturer instructions indicate otherwise; solution containers should remain in the warmer for no longer then 28 days at a temperature not to exceed 104 F (40C). a. When a bag or bottle is placed in the warmer, the date that the solution will expire is recorded on the container. b. If solution is not used by the expiration date it is discarded. c. Solutions are not re-warmed. If a solution is removed from the warmer and it is not used, it should be discarded. d. If warmer temperature exceeds 104 F, discard fluids. 3. Temperature is monitored continuously." Interview on 8/22/23 at 9:35 a.m. with director of nursing B revealed: *She had reviewed the manufacturer's	C 914		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 914	Continued From page 2 instructions for the storage of the two types of IV fluids. Both fluids were to have been stored below 104 F. *She confirmed they were not following the manufacturer's instructions or their policy for the safe storage of IV fluids.	C 914		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospital, was conducted from 8/21/23 through 8/23/23. Sanford Hospital Webster - CAH was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Hoxey | TITLE: CEO | (X6) DATE: 9/8/23

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10573S	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement 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 8/21/23 through 8/23/23. Sanford Hospital Webster was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Woeley — TITLE: CEO — (X6) DATE: 9/8/23

STATEMENT OF DEFICIENC ES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING 01 - ORIGINAL B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY, STATE. ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/22/23. Sanford Hospital Webster-CAH (building 1) was found not in compliance 42 CFR 485.623 (d) (1) requirements for Critical Access Hospitals. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/24/22. Please mark an F in the completion date column for K241 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223 and K907 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223	K223 Completion Date 9/8/2023 1. Accept this as the facility's allegation of compliance 2. On 9/8/2023 the Maintenance Director/Maintenance Director designee fixed the self closing doors by pharmacy and room 109 3. Beginning 9/8/2023, the facility Maintenance Director/Maintenance Director Designee will complete monthly audits of the doors for three months 4. The Quality Assurance and Performance Improvement Committee will monitor the finding of the audits to ensure compliance and for further recommendations	9/8/23 IL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Hoxey | TITLE: CEO | (X6) DATE: 9/8/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING **01 - ORIGINAL** B. WING _____	**08/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	**1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274**

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 1 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain two pairs of cross-corridor doors a (adjacent to the pharmacy and adjacent to patient room 109) as required. Findings include: 1. Observation on 8/22/23 at 10:15 a.m. revealed the cross corridor doors adjacent to the pharmacy could not fully close. The cross-corridor doors were held open with magnets tied into the fire alarm system. However, the doors could not fully close. There was a possibility that was caused by summer swelling of the doors, or it might have been because of installed edge protection. 2. Observation on 8/22/23 at 11:30 a.m. revealed the cross-corridor doors adjacent to patient room 109 could not fully close. The cross-corridor doors were held open with magnets tied into the fire alarm system. The closure problem was due to a non-functioning coordinator. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiencies affected one of numerous requirements for self-closing doors and had the potential to affect 100% of the occupants of the smoke compartments.	K 223		
K 241	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other,	K 241		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING 01 - ORIGINAL B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 241	Continued From page 2 and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4 19.2.4.1-19.2.4.4 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to maintain at least two conforming exits from the basement. Findings include: 1. Observation 8/22/23 at 11:45 a.m. revealed the basement was not provided with two approved means of egress. The basement boiler room was approximately 35 feet by 20 feet (700 square feet). The second exit discharged through the crawl space. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. The deficiency would not affect any of the patients and only minimal staff.	K 241		
K 907	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are	K 907	K907 Completion Date 9/14/2023 1. Accept this as the facility's allegation of compliance 2. On 9/8/23 a plan was adopted for hospital personnel to complete a risk assessment and an interdisciplinary plan to monitor and assess the medical gas system. Competencies will be completed with the Maintenance Director/Maintenance Director Designee on 9/14/23 on the medical gas system with the Aberdeen Maintenance Director/ Aberdeen Maintenance Director Designee. Maintenance Director will bring the information back to respiratory therapy, nursing and facilities to assure applicable provisions of the system are being documented and adhered to for maintenance and integrity of the system 3. Beginning on 9/8/2023, the facility Maintenance Director/Maintenance Director Designee will complete monthly audits of the medical gas system for any needed repairs three months 4. The Quality Assurance and Performance Improvement Committee will review the findings of the audits to ensure compliance and for further recommendations	9/14/23 IC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING 01 - ORIGINAL B. WING _____	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 907	Continued From page 3 established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to provide a maintenance plan for piped medical gases as required. Findings include: 1. Record review on 8/22/23 at 1:30 p.m. revealed a plan to provide medical gas outlet and system maintenance was not available. Interview with the maintenance director during the facility tour revealed no planning for maintenance or repair was available. The deficiency could impact any patients within the hospital.	K 907		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING _____ B. WING _____	R 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	1401 W FIRST ST POST OFFICE BOX 489 WEBSTER, SD 57274

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{C 000}	INITIAL COMMENTS A revisit survey was conducted on 9/18/23 for compliance with 42 CFR Part 484, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals for all previous deficiencies cited on 8/23/23. All deficiencies have been corrected and no new non-compliance was found. Sanford Hospital Webster -CAH was found in compliance with all regulations surveyed.	{C 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431311	A. BUILDING **01 - ORIGINAL** B. WING _____	R **09/20/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HOSPITAL WEBSTER - CAH	**1401 W FIRST ST POST OFFICE BOX 489** **WEBSTER, SD 57274**

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A revisit survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/20/23. Sanford Hospital Webster-CAH was found in compliance with 42 CFR 485.623 (d) (1) requirements for Critical Access Hospitals.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.