OMB NO. 0938-0391

	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 431507	A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2024						
NAME OF PROVIDER OR SUPPLIER  Avera @ Home			STREET ADDRESS, CITY, STATE, ZIP CODE  1115 E 5TH AVE , MITCHELL, South Dakota, 57301								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETIO DATE						
L0000	INITIAL COMMENTS  A recertification survey for corporate 418, Subparts C-D, requested from 5/21/24 throwas found in compliance.  A complaint health survey for Part 418, Subparts C-D, requested from 5/21/24 throwasted from 5/21/24 throwasted included potential abuse. Avecompliance.	ompliance with 42 CFR uirements for hospice, was ugh 5/22/24. Avera @ Home  r compliance with 42 CFR uirements for hospice, was ugh 5/22/24. Areas surveyed	L000								
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 reverse for further 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											

FORM OMS-2567 (02/99) Previous Versions Obsolete SD DCH-OEvent ID: 63112-H1

anette Voorhees

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

participation.

TITLE

(X6) DATE

05/30/2024

FORM APPROVED

OMB NO. 0938-0391

	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 431507		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/22/2024			
NAME OF PROVIDER OR SUPPLIER  Avera @ Home			STREET ADDRESS, CITY, STATE, ZIP CODE  1115 E 5TH AVE , MITCHELL, South Dakota, 57301						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO TH APPROPRIATE DEFICIENCY		SHOULD BE TO THE	(X5) COMPLETION DATE		
E0000	Initial Comments  A recertification health surve CFR Part 418, Subpart D, St Preparedness requirements from 5/21/24 to 5/22/24. Avercompliance.	ubsection 418.113, Emergency for hospice was conducted	E000	000					
Any deficier safeguards days following the	ncy statement ending with an as provide sufficient protection to ng the date of survey whether of de date these documents are ma	sterisk (*) denotes a deficiency which the patients. (See reverse for further or not a plan of operection is provide ade available to the facility. If deficien	n the instru I For	institu uction nursi are ci	ution may be excused from correcting properties.) Except for nursing homes, the finding homes, the above findings and plans ted, an approved plan of correction is re	roviding it is determine gs stated above are of s of correction are dis equisite to continued p	ed that other disclosable 90 closable 14 days program		

FORM CMS-2567 (02/99) Previous Versions Obsolete SD DCW OI 63112-H1 Facility ID: 11210

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

(X6) DATE

05/30/2024