

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

PRINTED: 08/06/2024  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>431306</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/01/2024</b> |
|--|---|--|---|

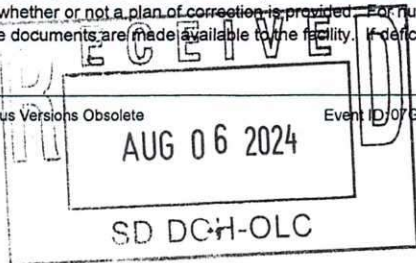
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|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PLATTE HEALTH CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>601 E 7TH ST POST OFFICE BOX 200<br/>PLATTE, SD 57369</b> |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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|-------|---|-------|--|--|
| C 000 | <p><b>INITIAL COMMENTS</b></p> <p>A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals (CAH) and Long-Term Care Services ("swing beds"), was conducted from 7/30/24 to 8/1/24. Platte Health Center was found in compliance.</p> | C 000 |  |  |
|-------|---|-------|--|--|

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|--|---------------------|------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Mark Burkett</i> | TITLE<br><b>CEO</b> | (X6) DATE<br><b>08/06/24</b> |
|--|---------------------|------------------------------|

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.



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|--|---|--|---|

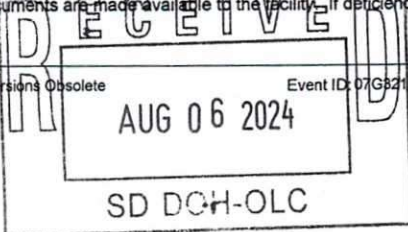
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| E 000 | <p>Initial Comments</p> <p>A recertification survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted on 7/30/24. Platte Health Center was found in compliance.</p> | E 000 |  |  |
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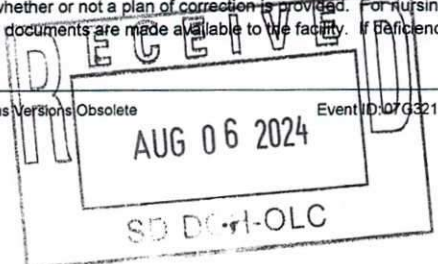
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| K 000 | <p><b>INITIAL COMMENTS</b></p> <p>A revisit survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 07/30/2024. Platte Health Center was found in compliance with 42 CFR 485.623 (d) (1) requirements for Critical Access Hospitals.</p> | K 000 |  |  |
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South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>10557S</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/01/2024</b> |
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|--------------------|---|---------------|---|--------------------|
| S 000              | <p>Compliance/Noncompliance Statement</p> <p>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 7/30/24 through 8/1/24. Platte Health Center was found in compliance.</p> | S 000         |   |                    |

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

TITLE  
CEO

(X6) DATE

*Mark Burkett*

08/06/24

STATE FORM

6899

N48011

If continuation sheet 1 of 1

