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

Medical CTR HHA was found in compliance.

PRINTED: 05/20/2024

FORM APPROVED

OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTIONS A. BUILDING 04/30/2024 437008 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **HURON REGIONAL MEDICAL CTR HHA** 530 IOWA AVE SE STE 107, HURON, South Dakota, 57350 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DATE APPROPRIATE DEFICIENCY) E0000 Initial Comments E0000 A recertification survey for compliance with 42 CFR Part 484, Subpart G. Subsection 484,102 Emergency Preparedness Requirements for Home Health Agencies, was conducted from 4/29/24 through 4/30/24. Huron Regional

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 of deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

MAY 2 1 2024

President / CEO

(X6) DATE 05/21/2024

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437008		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVI 04/30/2024	EY COMPLETED
NAME OF PROVIDER OR SUPPLIER HURON REGIONAL MEDICAL CTR HHA			STREET ADDRESS, CITY, STATE, ZIP CODE 530 IOWA AVE SE STE 107 , HURON, South Dakota, 57350			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 484, Subparts B-C, requirements for Home Health Agencies, was conducted from 4/29/24 through 4/30/24. Huron Regional Medical CTR HHA was found in compliance.		G0000			
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Ann de fini				titution may be excused from correcting pr		3

FORM CMS-2567 (02/99) Previous Versions Obsolete

LABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE MAY 2 1 2024

participation

__Event ID: 62D95-H1

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

President / CEO
Facility ID: SD437008

TITLE

If continuation sheet Page 1 of 1

05/21/2024

(X6) DATE