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

PRINTED: 08/01/2023 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | E SURVEY IPLETED | |
|--|--|---|---------------------|---|---|--------------------|---------------------|--|
| | | 43A072 | B. WING_ | | | 07 | 7/26/2023 | |
| NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH PLATTE, SD 57369 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI) TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | OULD BE COMPLETION | | |
| F 000 | INITIAL COMMENTS | | F | 000 | | | | |
| | with 42 CFR Part 483 for Long Term Care fa | h survey for compliance s, Subpart B, requirements acilities was conducted from 23. Platte Care Center was | | | | | | |
| | | | | | | | | |
| ABORATORY C | DIRECTOR'S OR PROVIDER/S | UPPLIER REPRESENTATIVE'S SIGNATURE | | | TITLE | | (X6) DATE | |
| Cord | ell Muilenbu | rg | | | Administrator | | 08/01/2023 | |

Any deficiency statement ending with an esterist (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection bethe patients. (See instructions), Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether purpose 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.

AUG 0 1 2023

Event ID: 7W2V11

SD DOH-OLC

Facility ID: 0030

Administrator

08/01/2023

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

PRINTED: 08/01/2023 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|------------------------------|---|--|----------------------------|---|---------------------------------|-------------------------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NOMBER. | A. BUILDING | | | - | |
| | | 43A072 | B. WING_ | | | 07/26/2023 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP (609 EAST 7TH | CODE | | |
| PLATTE C. | ARE CENTER | | | PLATTE, SD 57369 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | (X5) COMPLETION TE DATE | |
| E 000 | A recertification surv | ey for compliance with 42 | Ε(| 000 | | | |
| | Emergency Prepared Term Care facilities w | art B, Subsection 483.73, Iness, requirements for Long vas conducted from 7/25/23 te Care Center was found in | | | | | |
| | | | | | | | |
| | × | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | | (X6) DATE | |
| _ | dell Muilen | burg estensk (*) depotes a deficiency which the in | stitution ma | Administra ay be excused from correcting providing | | 08/01/2023 that | |

Any deticiency statement ending with an assess of detacles a detaclery, which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. See institutions. 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 hursing 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.

AUG 0 1 2023

SD DOH-OLC

Even ID: 7W2V11

Facility ID: 0030

If continuation sheet Page 1 of 1

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

PRINTED: 08/01/2023 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|--------------------|-------|---|----|----------------------------|--|
| | 43A072 B. W | | | | | 07 | 07/26/2023 | |
| | ROVIDER OR SUPPLIER | | | 609 E | EET ADDRESS, CITY, STATE, ZIP CODE EAST 7TH TTE, SD 57369 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| K 000 | A recertification surv Life Safety Code (LS occupancy) was cond Care Center was fou CFR 483.70 (a) required Facilities. | ey for compliance with the C) (2012 existing health care ducted on 7/26/23. Platte nd in compliance with 42 irements for Long Term Care | | 000 | TITLE | | (X6) DATE | |
| LABORATORY | DIRECTOR'S OR PROVIDER | /SUPPLIER REPRESENTATIVE'S SIGNATURE | = | | | | 08/01/202 | |
| Corde | ree rruneenou | ng | | | Administrator | | 00/01/202 | |

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 liabilities. (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 corrections 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.

AUG 0 1 2023

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

Event ID: 7W2V21

SD DOH-OLC

Facility ID: 0030

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South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 07/26/2023 B. WING 10664 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 E 7TH POST OFFICE BOX 200 PLATTE CARE CENTER **PLATTE, SD 57369** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/25/23 through 7/26/23. Platte Care Center was found in compliance. (X6) DATE TITLE Cordell Muilenburg

Administrator

DGB511

08/01/2023 If continuation sheet 1 of 1

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STATE FORM