DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2023 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435135	B. WING			06/28/2023	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL AN	D NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP C 102 MAJOR ALLEN MARTIN, SD 57551	CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BI THE APPROPRIA	(X5) E COMPLETION THE DATE	
F 000	with 42 CFR Part 483 for Long Term Care for 6/26/23 through 6/28/	th survey for compliance B, Subpart B, requirements acilities was conducted from /23. Bennett County Hospital as found in compliance.	FO	000			
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE Shigh	TITLE Adminis	strator	(X6) DATE 7/10/23	

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

Event 10: 9ZJW11

FORM CMS-2567(02-99) Previous Versions Obsolete 1 0 2023

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		435135	B. WING	<u>.</u>	06/28/2023
NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP C 102 MAJOR ALLEN MARTIN, SD 57551	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
E 000	CFR Part 482, Subpa Emergency Prepared Term Care facilities w	ey for compliance with 42 art B, Subsection 483.73, Iness, requirements for Long vas conducted from 6/26/23 nett County Hospital and bund in compliance.	E	000	
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE //	TITLE Admir	nistrator (X6) DATE 7/16

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 to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whetherer not 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.

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

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program participation.

Event ID: 9ZJW11

Facility ID: 0037

If continuation sheet Page 1 of 1

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

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STATEMENT OF AND PLAN OF H	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435135			01		
	OVIDER OR SUPPLIER	435135		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	OVIDER OR SUPPLIER		B. WING			06/2	27/2023
	COUNTY HOSPITAL AN	NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME			TY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 000	A recertification surve Life Safety Code (LSO occupancy) was cond County Hospital and	ey for compliance with the C) (2012 existing health care ducted on 6/27/23. Bennett Nursing Home was found in EFR 483.70 (a) requirements	K	000	DEFICIENCY)		
LABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E Ship	1H	TITLE Administrator		(X6) DATE 7/10/23

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. (Secundary Secundary) 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 previded. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the feetity. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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vent ID 9ZJW21

FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 06/28/2023 B. WING 10646 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 102 MAJOR ALLEN POST OFFICE BOX 70 BENNETT COUNTY HOSPITAL AND NURSING HOME **MARTIN, SD 57551** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (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 6/26/23 through 6/28/23. Bennett County Hospital and Nursing Home was found in compliance. S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/26/23 through 6/28/23. Bennett County Hospital and Nursing Home was found in compliance.

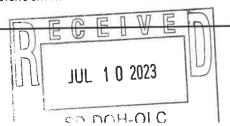
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shight of

TITLE Administrator

(X6) DATE 07/10/23

STATE FORM



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