DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/21/2024 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FUR WEDICARE & | MEDICAID SERVICES | | | 1 | | |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------|-----------|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 43A067 | B. WNG_ | | 02 | /29/2024 | |
| NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078 | | | |
| (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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| E 000 | Initial Comments | | E 0 | 000 | | | |
| F 000 | CFR Part 482, Subpa Emergency Prepared Term Care facilities w through 2/29/24. SD Geriatric Program wa INITIAL COMMENTS A recertification heal with 42 CFR Part 483 for Long Term Care for | th survey for compliance 3, Subpart B, requirements acilities was conducted from /24. SD Human Services | FO | 000 | | | |
| | | | | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATU | JRE | TITLE | | (X6) DATE | |

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.

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: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 | | (X3) DATE SURVEY COMPLETED | | |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------|----------------------------|
| | | 43A067 | B. WING | | | 02/27/2024 | |
| NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM | | | | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 515 BROADWAY AVE (ANKTON, SD 57078 | | |
| (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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | | K | K 000 | | | |
| K 000 | Life Safety Code (LSC occupancy) was cond Human Services Cen (Building 01) was four | ey for compliance with the C) (2012 existing health care lucted on 2/27/24. SD ter - Geriatric Program and in compliance with 42 rements for Long Term Care | K | 000 | | | |
| | Life Safety Code (LSC occupancy) was cond Human Services Cen (Building 02) was four | ey for compliance with the C) (2012 existing health care flucted on 2/27/24. SD ter - Geriatric Program and in compliance with 42 rements for Long Term Care | | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDERS | SUPPLIER REPRESENTATIVE'S SIGNATUR | F | | TITLE | | (X6) DATE |

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.

South Dakota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 02/29/2024 10719SD STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3515 BROADWAY AVE POST OFFICE BOX 7600 SD HUMAN SERVICES CENTER - GERIATRIC PROGR YANKTON, SD 57078 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (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 2/26/24 through 2/29/24. SD Human Services Center - Geriatric Program 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 2/26/24 through 2/29/24. SD Human Services Center -Geriatric Program was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amelia Henderson, NHA MAR 0 8 2024 SD DOH-OLC

STATE FORM

TITLE

(X6) DATE

Program Director

N6Y011

03/08/2024

If continuation sheet 1 of 1