## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2024 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		431306	B. WING_		08/01/2024
NAME OF PROVIDER OR SUPPLIER  PLATTE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 601 E 7TH ST POST OFFICE BOX 20 PLATTE, SD 57369	ODE
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETION DATE
C 000	INITIAL COMMENTS		CO	00	
	with 42 CFR Part 485 485.605-485.645, red Access Hospitals (CA Services ("swing beds	th survey for compliance 6, Subpart F, Subsections guirements for Critical 8H) and Long-Term Care s"), was conducted from the Health Center was found			м
				la la	
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Mark Burket			TITLE	(X6) DATE 08/06/24	
ner safeguard	ds provide sufficient protection ate of survey whether or not the date these documents a	on to the patients. (See instructions.) E	xcept for nursing	be excused from correcting providing it is g homes, the findings stated above are di above findings and plans of correction a , an approved plan of correction is requis	sclosable 90 days
RM CMS-2567	7(02-99) Previous Versions Obse	AUG 0 6 2024 Event 10-00	3311	Facility ID: 10557	If continuation sheet Page 1 of 1

SD DCH-OLC

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
	431306		B. WNG		07	07/30/2024	
NAME OF PROVIDER OR SUPPLIER  PLATTE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  601 E 7TH ST POST OFFICE BOX 200  PLATTE, SD 57369			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
	CFR Part 485, Subpa Emergency Prepared Critical Access Hospi	ey for compliance with 42 art F, Subsection 485.625, dness, requirements for itals, was conducted on h Center was found in					
8							
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE	(X6) DATE 08/06/24		

SD DOH-OLC

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2024 FORM APPROVED

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 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED		
		431306	B. WING			07/	30/2024	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PLATTE H	EALTH CENTER			1000	01 E 7TH ST POST OFFICE BOX 200 LATTE, SD 57369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EIX E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E ACTION SHOULD BE TO THE APPROPRIATE		
K 000	Safety Code (LSC) (2 occupancy) was cond Health Center was for	ompliance with the Life 2012 existing health care ducted on 07/30/2024. Platte and in compliance with 42 requirements for Critical	К	000				
	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE CEO	08	(X6) DATE /06/24	

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 a value to the facility. If participation.

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

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Facility ID: 10557

If continuation sheet Page 1 of 1

South Dakota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG 10557S 08/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 601 E 7TH ST POST OFFICE BOX 200 PLATTE HEALTH CENTER PLATTE, SD 57369 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 Compliance/Noncompliance Statement S 000 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. (X6) DATE TITLE

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Wark Burket E G E V E 0 08/06/24

STATE FORM

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