

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2017
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NAME OF PROVIDER OR SUPPLIER SANFORD USD MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 W 18TH STREET SIOUX FALLS, sd 57117
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Compliance/Noncompliance statement</p> <p>Surveyor: 99999</p> <p>Surveyor: 04790</p> <p>A statistical data survey for compliance with SDCL 34-23A, Performance of Abortions, was conducted on 8/1/17. Sanford USD Medical Center was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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