

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10745	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/06/2023
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NAME OF PROVIDER OR SUPPLIER THE INN ON WESTPORT	STREET ADDRESS, CITY, STATE, ZIP CODE 4000 S. WESTPORT AVENUE SIOUX FALLS, SD 57103
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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
S 000	<p>Compliance Statement</p> <p>A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 7/5/23 through 7/6/23. Areas surveyed included abuse and neglect, and administration/personnel. The Inn on Westport was found in compliance.</p>	S 000		

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

Ka Falt

TITLE

Executive Director

(X6) DATE

7-20-23

STATE FORM

LWSC11

If continuation sheet 1 of 1

