STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435084	A. BUILDING B. WING	09/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faulkton Senior Living	1401 Pearl St , Faulkton, South Dakota, 57438

(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) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/15/26. Faulkton Senior Living was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda R. Ferguson	Executive Director	10/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. Faulkton Senior Living was found not in compliance with the following requirements: F583, F641, F644, F655, F732, F761, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. Areas surveyed included residents' quality of life and quality of care. Faulkton Senior Living was found in compliance.	F0000		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F0761		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda R Ferguson Brenda R Ferguson	Executive Director	10/21/2026 10/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0761 SS = E	Continued from page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that medications were labeled, unexpired, and securely stored for one of one whirlpool tub room that contained Nystatin powder (an antifungal powder), medicated shampoo, and for two of two medication carts that had medications without pharmacy labels, and Bio freeze (a medicated pain relief gel) was stored in its original container. Findings include: 1. Observation on 9/16/26 at 11:00 a.m. in the whirlpool tub room with certified nursing assistant (CNA) H revealed two partially used Nystatin powder bottles stored on a supply shelf. One bottle expired on 5/31/26 and was not labeled for a resident. The second bottle's expiration date was unreadable and was not labeled for a resident. Bottle two had a partially removed pharmacy label. A medicated shampoo labeled for resident 11 and another medicated shampoo, labeled with a first name that no current resident had, were also stored in the tub-room closet. 2. Observations and interview on 9/16/26 at 2:17 p.m. with licensed practical nurse (LPN) E revealed a plastic bag in the south hall medication cart contained a medication bottle with a handwritten label for resident 14. The bottle was identified by LPN E as calcitonin nasal spray (a nasal spray used to treat bone loss), and it did not have a pharmacy label, resident identification, or usage instructions to verify against the resident's medication administration record (MAR). Inside the medication cart, there was a specimen cup labeled "Biofreeze" that was transferred from a stock pump bottle because the original container "did not fit on the cart." The specimen cup lacked manufacturer instructions, a pharmacy label, a lot number, and an expiration date. 3. Observations and interview on 9/16/26 at 2:45 p.m. with certified medication aide (CMA) M at the north medication cart revealed a bottle of 6.5% (percent) carbamide peroxide ear drops with no pharmacy label, resident name, or usage directions. CMA M stated she relied on the pharmacy label to identify how to administer medications and that she did not know which resident the ear drops belonged to.	F0761	F 0761 PLAN OF CORRECTION 1. In continuing compliance with F 0761, Label/Store Drugs and Biologicals, Faulkton Senior Living corrected the deficiency by removing medicated shampoos and Nystatin powders from the bathing room and unlabeled medications from medication carts on 09/18/2026. The bathing room was audited to ensure no storage of medicated powders, creams or shampoos on 09/18/2026. All medication and treatment carts were on audited on 09/18/2026 to ensure all unlabeled and expired medications/treatments were removed. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff responsible for medication administration will be educated by the Director of Nursing Services by 10/22/2026 on secure storage, labeling and dating of medications. The Director of Nursing Services and/or Designee will audit medication/treatment carts and bathing area to ensure proper storage, labeling, and dating of medications weekly for four weeks, monthly for two months and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns from audits through the community's QA Process.	10/22/2026

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F0761 SS = E	Continued from page 2 There were two bottles of artificial tears in the north medication cart. One was unlabeled and the other was labeled only with a handwritten note. The note read “Resident 3’s eye drops – artificial tears.” Neither bottle included a pharmacy label to identify the resident name, or dosing instructions. 4. Interview on 9/17/26 at 10:21 a.m. with CMA M revealed Resident 3's Refresh eye drops were discontinued. CMA M stated the discontinued eye drops “must not have been removed from the medication cart.” She stated the nurses were responsible for removing discontinued medications from the medication carts. 5. Interview on 9/17/26 at 2:10 p.m. with CNA K acknowledged that CNAs, maintenance staff, nursing staff, and housekeeping staff, were unsupervised by nurses while in the tub room, which indicated there was unauthorized staff who had access to medications including Nystatin and medicated shampoos. 6. Interview on 9/17/26 at 3:27 p.m. with LPN E revealed that she only transferred Biofreeze into a specimen cup and did not do that for any other medications. She acknowledged that she did not notice that the calcitonin nasal spray lacked a pharmacy label and confirmed that she would not be able to verify usage instructions or identify the correct resident to administer the medication to without proper labeling. She stated the facility supplied stock medications such as artificial tears and ear drops to residents and those stock medications would not have a pharmacy label on them to indicate which resident the medication belonged to, or how to administer that medication. She stated that the nurses checked the medication carts monthly for expired medications and were to verify the expiration dates before they administered the medication to residents. 7. Interview on 9/17/26 at 3:42 p.m. with director of nursing (DON) B revealed that medications without readable pharmacy labels were expected to be returned to the pharmacy for relabeling or be disposed of. She stated the nurses were not permitted to transfer medications between containers and that proper labeling was required to identify the correct resident, verify directions against the resident's MAR, and ensure safe administration. She confirmed that unlabeled medications could result in incorrect or wrong-resident administration. 8. Review of resident 14’s electronic medical record	F0761		

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F0761 SS = E	Continued from page 3 (EMR) revealed a 1/28/25 physician's order dated for calcitonin nasal spray once per day. 9. Review of resident 3's EMR revealed that there were no active physician's orders for eye or ear medications. 10. Review of the provider's January 2018 Medication ordering and receiving from pharmacy policy revealed that medications must be stored securely and accessible only to licensed staff; outdated or illegible medications must be removed immediately; all medications must be clearly labeled with resident name, medication name, strength, dosage, and expiration date. 11. Review of the provider's March 2025 medication storage policy revealed that medications must be stored securely and accessible only to licensed staff; outdated or illegible medications must be removed immediately; all medications must be clearly labeled with resident name, medication name, strength, dosage, and expiration date. 12. Review of the providers' December 2025 Medication Administration Policy revealed that nurses must: complete label-to-MAR checks during all steps of administration, administer medications from original labeled containers only, never administer unlabeled or transferred medications, and follow pharmacy directions to prevent misadministration and contamination.	F0761		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F0880		

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F0880 SS = E	Continued from page 4 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880	F 0880 PLAN OF CORRECTION 1. In continuing compliance with F 0880, Infection Prevention and Control, Faulkton Senior Living corrected the deficiency by educating CNA H on whirlpool cleaning/disinfecting manufacturer instructions on 10/16/2026. In the soiled utility room on the 300 hallway, the bottled water and emergency supply totes were removed and room was cleaned. A splash guard was ordered 10/10/20226 and will be installed upon arrival. In the whirlpool room, the open bar of soap, unlabeled basket and its contents were disposed of on 09/18/2026. The white plastic cabinet was removed on 10/06/2026. Maintenance will remove non-slip tape and residue by 10/19/2026. Maintenance will fix exposed drywall, cracks to whirlpool/jets, and tile behind whirlpool by 10/30/2026. Whirlpool seat replacement was ordered on 10/12/2026 and will be replaced upon arrival. Broken soap dispenser will be replaced by 10/30/2026. The whirlpool room was cleaned by housekeeping on 10/12/2026 which included the closet floor, windowsills, whirlpool chair scale and wheels. Laundry aide G was educated on ensuring linen carts remain covered in the hallway when delivering linens by Environmental Services Director on 10/16/2026. CNA J was educated on ensuring catheter tubing is secured to wheelchair so that it does not d rag on floor for R3 and all like residents by Director of Nursing Services on 10/16/2026. CNA J & CNA L were educated on proper hand hygiene between glove usage during cares for R3, R23 and all like residents by the Director of Nursing Services on 10/16/2026.	Type text 10/30/2026

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F0880 SS = E	Continued from page 5 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding: one of three linen carts that was left uncovered in the 100 hallway, one of one certified nursing assistant (CNA) L who did not secure one of one sampled resident (3) catheter (flexible tubing placed in the bladder to drain urine) tubing to his wheelchair to prevent the catheter tubing secured to his wheelchair to prevent the catheter tubing from dragging on the floor, two of two certified nursing assistants (CNAs) (J and L) who did not perform hand hygiene (handwashing or hand sanitizer use) before and after glove use while providing personal cares for two of two sampled residents (3 and 23), for one of three soiled utility rooms near a hopper (a specialized sink flushing device used to rinse soiled items and linens of body fluids), and one of one whirlpool tub room that was not cleaned, disinfected, and maintained according to the manufacturer's instructions and the facility's policy. Findings include: 1. Observation on 9/16/26 at 9:59 a.m. of CNA H in the whirlpool tub room revealed after completing a resident's bath CNA/bath aide H turned the whirlpool tub knobs to initiate cleaning, filled the tub water, left the whirlpool tub chair inside the tub turned on the jets, and scrubbed the side of the whirlpool tub and whirlpool tub and chair with a scrub brush. CNA H's cleaning procedure did not follow the manufacturer's instructions and failed to ensure the tub and air-spa jets were disinfected as required. 2. Observation on 9/16/26 at 2:05 p.m. of the soiled utility room located in the 300 hallway revealed the room contained a hopper without a splash guard. A case of bottled water was stored under the sink near the hopper. Three sealed totes marked “Emergency Kits” were also stored under the sink. Dead bugs were observed on the floor and soiled gloves were in the corner of the room on the floor. 3. Observation on 9/16/26 at 3:29 p.m. of the whirlpool room revealed an unlabeled basket stored on a shelf beside the shower. Inside the basket was a Lady Speed Stick deodorant with gray residue on the outer container and a Secret deodorant with a	F0880	2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing Services educated all nursing staff on the manufacturer instructions for cleaning/disinfecting the whirlpool, securing catheter tubing underneath wheelchairs, and proper hand hygiene between glove usage on 10/22/2026. Environmental Services Director educated housekeeping staff on whirlpool room and soiled utility cleaning to expectations and keeping linen carts covered in hallways during delivery by 10/22/2026. The Executive Director educated Environmental Services Director on ensuring whirlpool tub/room and soiled utility rooms are maintained and all repairs are completed timely by 10/16/2026. The Director of Nursing Services will audit whirlpool tub cleaning/disinfecting 2 times per week for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The Director of Nursing Services will audit hand hygiene between glove usage 2 times per week for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The Environmental Services Director will audit linen cart covering weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The Environmental Services Director will audit whirlpool room for cleanliness and timely repairs weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. The Environmental Services Director will audit soiled utility rooms to ensure cleanliness, proper storage of items, and splash guard intactness weekly for 4 weeks, monthly for 2 months and randomly to ensure continued compliance. 3. As part of Faulkton Senior Living’s ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns from audits through the community’s QA Process. Addendum: All other soiled utility rooms were audited to ensure cleanliness, inappropriately stored items removed, and splash guards ordered 10/20/2026. Maintenance will fix cracks to whirlpool drain/jets and openings to jet per manufacturer guidelines to ensure cleanable surface by 10/30/26.	

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F0880 SS = E	Continued from page 6 brownish ring around the deodorant surface. A hairbrush containing multiple hair colors in the bristles was also present. Peeling black non-slip tape was noted on the grab bar on the wall, and on the floor beneath the grab bar was a black sticky residue surrounding tape on the floor. Exposed drywall was present on the wall next to the whirlpool tub. There were cracks around the whirlpool tub drain and jet openings, including a missing portion around one jet opening that created a gap large enough for a fingernail to be inserted, making the surface uncleanable. The whirlpool chair seat was cracked. Tiles behind the whirlpool tub were cracked and missing, exposing the tile backing. Copious amounts of dust and lint were on the windowsill. An open and used bar of soap was observed in the shower area. The bath scale that attached beneath the whirlpool chair had white, flaky buildup underneath, and the scale wheels contained hair of multiple colors wrapped around and embedded inside them. The closet located inside the whirlpool room stored resident-care supplies shelves. The closet floor had a layer of thick brown dust, and debris, including dry wall dust, and hair. The bathroom attached to the whirlpool tub room revealed a broken soap dispenser. A white plastic cabinet contained an open, partially used tube of toothpaste and a bottle of mouthwash without resident identifiers. The top of the cabinet had a dried orange liquid, brown debris, black flecks on it, and wrapped toilet paper rolls were placed directly on top of the debris. 4. Interview on 9/17/26 at 1:15 p.m. with housekeeping aide O revealed he swept and mopped the floor. He scrubbed the floor grout monthly. He stated the walls were cleaned monthly unless visibly soiled. He did not clean broken drywall because cleaning it would worsen the damage. He stated maintenance director N was responsible for addressing the damage, but acknowledged that the cracked tiles, broken sheetrock, and damaged fixtures observed in the whirlpool tub room were not fixed. He stated the windows were not cleaned recently due to them pending replacement and that the window screens were cleaned monthly. He stated the CNAs were responsible for cleaning the bath scale and reported there was no cleaning checklist for the whirlpool tub room. 5. Interview on 9/17/26 at 3:42 p.m. with director of nursing (DON) B revealed the black tape placed on	F0880		

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F0880 SS = E	Continued from page 7 the grab bar and on the floor in the whirlpool tub room created an uncleanable surface. She stated CNA bath aides were responsible for cleaning the tub room and whirlpool equipment after each resident use. She was not aware of the cracks in the tub, cracked tiles, exposed drywall, buildup of dust on the windowsill, shared deodorants, shared grooming items, or environmental debris in the whirlpool tub room areas. She acknowledged that cracked surfaces could not be disinfected and that shared grooming items posed cross-contamination risks to the resident. 6. Interview on 9/17/26 at 4:10 p.m. with administrator A revealed maintenance director N was out of the facility and unavailable for an interview during the time of the survey. 7. Review of the provider's undated Housekeeping Guidelines revealed the daily expectations for whirlpool tub and shower rooms included cleaning light fixtures, switches, grab bars, door frames, sweeping and mopping floors, and removing garbage. 8. Review of the manufacturer's whirlpool cleaning and disinfecting instructions revealed the required sequential steps included closing and locking the whirlpool tub door, closing the drain, turning the air spa blower on, turning the selector knob to "TUB CLEANER," waiting for foamy cleaning solution to exit all jets, scrubbing the tub and chair with the tub brush, turning the selector knob to "RINSE," rinsing with the shower wand, and purging air-spa lines. The disinfecting cycle required the staff to turn the selector knob to "DISINFECTANT," turn the ON/OFF valve to "ON," apply disinfectant to the tub surface and chair, and allow a ten-minute contact time before rinsing. 9. Observation on 9/15/26 at 9:34 a.m. of a linen cart in the 100-hallway revealed that the linen cart had a cover on it that could cover the top and all four sides of the cart. The front panel of the cover was draped over the top of the linen cart. A quilt and bed sheet was laid on top of the front cover that was draped over the top of the linen cart. Inside the cart were bed sheets, blankets, mattress covers, and absorbent bed pads. Residents were walking in the hallway near the linen cart. There were no staff in the hallway. 10. Observation on 9/17/26 at 8:14 a.m. of CNAs J and L providing personal care for resident 3 revealed	F0880		

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F0880 SS = E	Continued from page 8 that on the outside of resident 3's door was a sign that indicated he was on enhanced barrier precautions (EBP, glove and gown use when providing contact care). Resident 3 was lying in bed. He had a catheter urine collection bag hanging on the bed frame. CNAs L and J each put on a gown, performed hand hygiene, and put on a pair of gloves. CNAs J and L each put a compression sock on resident 3's feet. CNA J unfastened resident 3's incontinence (involuntary urine or bowel leakage) brief and wiped resident 3's catheter tubing with alcohol pads from his bedside stand. CNA J then performed resident 3's personal hygiene care with a wet washcloth from the bathroom. With those same gloved hands, CNA J grabbed a clean incontinence brief from resident 3's recliner, tucked it under resident 3, and put a clean pair of pants on his legs. She did not remove and discard her soiled gloves or perform hand hygiene. CNA L grabbed a plastic container from resident 3's bathroom, placed it on a paper towel on the floor beside resident 3's bed, and emptied resident 3's urine from his catheter bag into the plastic container. After the catheter bag was emptied, CNA L clamped the catheter bag drainage tube and cleaned the tube with an alcohol wipe from resident 3's bedside stand. CNA L emptied the plastic container into the toilet, turned on the faucet at the sink, filled the plastic container with water, dumped that water into the toilet, and placed the plastic container on a shelf in the bathroom. CNA L removed her gloves, disposed of her gloves in the trash can, and put on a new pair of gloves without performing hand hygiene. CNA J and CNA L each put resident 3's shoes on his feet. CNA J removed her gloves, disposed of those gloves in the trash can, and put on a new pair of gloves without performing hand hygiene. CNA L rolled resident 3 to his right side, and CNA J washed resident 3's buttocks with a disposable wipe and applied a protective barrier cream. CNA J removed her gloves, disposed of those gloves in the trash can, and put on a new pair of gloves without performing hand hygiene. CNA J rolled resident 3 onto his left side, and untucked resident 3's clean incontinence brief, out from under him, rolled resident 3 onto his back, and secured resident 3 incontinence brief. CNA L and J pulled up resident 3's pants. CNAs J and L removed their gloves, disposed of them in the trash can, and each put on a new pair of	F0880		

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F0880 SS = E	Continued from page 9 gloves without performing hand hygiene. CNA L used a wet washcloth from resident 3's bathroom to wash resident 3's face. CNA J and L assisted resident 3 to a seated position on the side of his bed. CNA J put deodorant on resident 3 and CNA L put a clean shirt on him. CNA L put a gait belt (a waist strap gripped as support for safe mobility and transfers) around resident 3's waist and CNAs J and L used that gait belt to assist resident 3 to a standing position and transferred him from his bed to his wheelchair. CNA L handed resident 3 his electric razor from his bedside stand and he began shaving his face. CNAs J and L made resident 3's bed and put resident 3's soiled clothes in a plastic bag. CNA L removed her gown and gloves, disposed of them in the trash can, and did not perform hand hygiene. With her unclean hands, CNA L took the electric razor from resident 3 and plugged it into the charger on resident 3's bedside stand. She took the bag of dirty laundry out of resident 3's room, put it in a bin in the hallway, and did not perform hand hygiene. CNA J removed her gown and gloves, disposed of them in the trash can, and performed hand hygiene. She removed the bag of trash from the trash can, put a new bag in the trash can, and took the trash into the hallway and disposed of it in a bin. CNA J entered resident 23's room without performing hand hygiene. 11. Observation on 9/17/26 at 8:45 a.m. of CNAs J and L providing personal cares for resident 23 revealed they entered resident 23's room, washed their hands in the bathroom sink and put on a pair of gloves. While resident 23 was lying in bed, CNA J removed resident 23's blankets, the protective heel boots , (a cushioned boot that floats the heel off the surface of the mattress, to help reduce pressure) she was wearing, and unfastened resident 23's soiled incontinence brief. CNA J then performed personal cares using a disposable wipe. CNA L assisted CNA J with performing personal cares using a disposable wipe, turned resident 23 on her left side and tucked the soiled brief under resident 23. CNA L wiped resident 23's buttocks with a disposable wipe, put a protective cream on resident 23's buttocks and with the same gloved hands placed a clean brief under resident 23. With the same gloved hands CNAs J and L put socks on resident 23's feet. CNA L put on resident 23's pants. CNA J removed her gloves, disposed of them in the trash can, and put on a new pair of gloves without	F0880		

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F0880 SS = E	Continued from page 10 performing hand hygiene. CNA L and J assisted resident 23 to a seated position on the side of her bed. CNA J removed resident 23's pajama top and assisted resident 23 with putting on a clean shirt. CNA L removed her gloves, disposed of them in the trash can, and put on a new pair of gloves without performing hand hygiene. CNA L wet a washcloth in the bathroom sink, washed resident 23's face and hands, laid the washcloth on the bedside table, and put a gait belt around resident 23's waist. With their same gloved hands, CNA L and J assisted resident 23 to a standing position and transferred her from her bed to her wheelchair. CNA L brushed resident 23's hair. CNA J cleaned and put on resident 23's glasses. CNA L removed her gloves, disposed of the gloves in the trash can, performed hand hygiene, and pushed resident 23 out of her room in her wheelchair. CNA J put the dirty laundry in a plastic bag, removed the garbage bag from the trash can, and put a new trash bag in the trash can. CNA J removed her gloves, took the bag of dirty laundry and the trash into the hallway, disposed of them in bins, and performed hand hygiene. 12. Observation on 9/17/26 at 10:15 a.m. of resident 3 sitting in his wheelchair in the common area revealed his urinary catheter bag was secured under his wheelchair. The tubing of his urinary catheter bag was lying on the floor under his wheelchair. 13. Interview on 9/17/26 at 9:03 a.m. with CNA J revealed that hand hygiene should be completed when the staff entered and exited a resident's room, between dirty and clean tasks, and between glove changes. She acknowledged that she had missed opportunities for hand hygiene when she changed her gloves during resident 3 and 23's personal cares. 14. Interview on 9/17/26 at 1:39 p.m. with certified medication aide (CMA) M revealed that the linen was passed out to the residents by laundry services aide G in the morning. Linen was to be covered when it was in the hallway. The staff used the hoppers in the dirty utility rooms to rinse off soiled clothing and bedding. A resident's catheter tubing should be secured to	F0880		

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F0880 SS = E	Continued from page 11 prevent it from being on the floor. If a resident's catheter tubing was on the floor, it would be contaminated and there was potential for it to cause an infection to that resident. 15. Interview on 9/17/26 at 3:16 p.m. with director of nursing (DON) B revealed that she expected the staff to change their gloves between soiled and clean tasks. She expected the staff to perform hand hygiene before putting on gloves, after taking off their gloves, and between changing their gloves. She expected a resident's catheter tubing to be secured so it did not touch the floor. If it touched the floor, there was a potential for it to cause that resident an infection. She was not aware there was bottled water and emergency kits stored in the soiled utility rooms near the hoppers. 16. Interview on 9/17/26 at 3:36 p.m. with licensed practical nurse (LPN) E revealed that the staff was to change their gloves when they went from a dirty to clean task during a resident's personal cares. She expected the staff to perform hand hygiene before they entered a resident's room, when they left a resident's room, after touching an object that could be potentially soiled, before they put on their gloves, after they removed their gloves, and when they changed their gloves. 17. Review of the provider's undated Handling Clean Linen policy revealed, "It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection." "Clean linen shall be delivered to resident care units on covered linen carts with covers down. Nothing shall be kept on top of the linen carts." 18. Review of the provider's 4/20/26 Catheter Care policy revealed there was no information related to securing catheter tubing. 19. Review of the provider's 4/20/26 Hand Hygiene policy revealed "Proper hand washing techniques should be used to protect against the spread of infection." Alcohol based hand sanitizer should be used, "Immediately before putting on gloves and after glove removal."	F0880		

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F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to protect the residents' personal and medical information for one of one sampled resident (6) whose name was heard over the staff's walkie-talkies in the dining room regarding her care assistance, and for 35 of 35 (all current residents residing in the facility on 9/15/26) whose names were posted in the whirlpool room with their religious practices. Findings include: 1. Observation on 9/15/26 at 11:58 a.m. in the	F0583	F 0583 PLAN OF CORRECTION 1. In continuing compliance with F 0583, Personal Privacy/Confidentiality of Records, Faulkton Senior Living corrected the deficiency by removing the identified posted information from the whirlpool room on 09/18/2026. R6 and all like resident names were removed from the call light system on 09/18/2026. CNA L was educated by the Director of Nursing Services on ensuring R2, R33 and all other resident names are not utilized over the walkie talkies on 10/16/2026. 2. To correct the deficiency and to ensure the problem does not recur all staff that utilize walkie talkies were educated by the Director of Nursing Services on ensuring resident names are not utilized over the walkie talkies by 10/22/2026. The Executive Director educated all staff responsible for programming the call system to ensure resident names are not utilized by 10/22/2026. The Executive Director educated the Activities Director on ensuring HIPPA is maintained with any resident postings on 10/16/2026. The Director of Nursing and/or designee will audit employee communication for HIPPA compliance weekly for 4 weeks, monthly for two months and then randomly to ensure continued compliance. The Executive Director and/or designee will audit resident postings and walkie talkie programming for HIPPA compliance weekly for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. 3.As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns from audits through the community's QA Process.	10/26/2026

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F0583 SS = D	Continued from page 13 dining room revealed a staff member's walkie- talkie was paging information that "[resident 6] fall pad" had alarmed. 2. Observation on 9/15/26 at 12:07 p.m. in the dining room during the noon meal revealed CNA H asked CNA L which residents were not in the dining room. CNA L stated that residents 2 and 33 were using the bathroom and she would bring them into the dining room as soon as they were done in the bathroom. There were multiple residents seated in the dining room near the CNA L when she stated residents 2 and 33 were using the bathroom. 3. Observation on 9/16/26 at 11:30 a.m. revealed a staff member's walki- talkie was paging information that "[resident 6] fall pad" had alarmed. 4. Observation of the tub room on 9/16/2026 at 3:29 p.m. in the 100s hall revealed a posted document on the wall facing the whirlpool tub that listed residents' religious practices and names, along with an additional posted list showing residents' medical appointment dates and times. 5. Interview on 9/17/26 at 1:44 p.m. with certified nursing assistant (CNA) I revealed she had received HIPAA (Health Insurance Portability and Accountability Act, a U.S. federal law passed in 1996 that protects sensitive patient health information from being shared without consent) and privacy training. She stated that the staff were instructed not to say residents' names over the walkie-talkies and instead use resident initials or room numbers. She stated that the staff used walkie-talkies to communicate the residents' assistance needs and acknowledged that using the resident names over the walkie-talkies was not appropriate. She said she was expected to take any document she found with residents' personal information to the nurses' station and lay it face down next to the nurse's computer. 6. Interview on 9/17/26 at 1:57 p.m. with director of nursing (DON) B revealed that the fall mats were programmed to automatically announce over staff's walkie-talkies when there was an issue. She was not aware that resident names were being communicated over the staff's walkie-talkies and confirmed that would be considered a privacy issue. She stated resident 6 was the only current resident who utilized	F0583	Addendum: Type text here CNA L was educated by the Director of Nursing Services on ensuring R2, R33 and all other resident names are not utilized over the walkie talkies or in personal conversation in front of others to maintain resident personal privacy by 10/22/2026. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by the Director of Nursing Services on ensuring resident names are not utilized in personal conversation in front of others to maintain resident personal privacy by 10/22/2026.	

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F0583 SS = D	Continued from page 14 a fall mat. Regarding the posted religious practices and names, DON B stated the activities director (AD) F posted the religious information and that she did not agree with posting residents' religious information in the tub room. She did not know whether AD F obtained permission from the residents to post that information. 7. Interview on 9/17/26 at 1:57 p.m. with administrator A regarding the staff's use of walkie-talkies revealed that the staff can adjust the volume of the device's volume. She was not aware resident 6's name was used when the call system announced her "fall pad". She stated maintenance director N was responsible for programming the call system that announces over the staff members walkie-talkies, and he should not have programmed her name into the system. He should have used her room number. 8. Interview with AD F on 9/17/26 at 3:10 p.m. revealed she obtained verbal permission from the residents to post their religious information on the document posted in the whirlpool tub room. She stated there was no documentation to support that she asked the resident or the resident representative for their consent to display their religious affiliations. 9. Interview on 9/17/26 at 3:56 p.m. with director of nursing (DON) B revealed that she expected the staff not to state that a resident was using the bathroom while in the dining room with other residents present. 10. Maintenance director N was not available for an interview on 9/17/26. 11. Review of the provider's February 2019 Notice of Privacy Practices revealed they "have protections in place to keep your information from being seen by anyone who should not see it." "Facility's entities, employees, volunteers, and agents will follow this notice. The notice applies to all records of the care you got at this facility." 12. Review of the provider's Residents' Bill of Rights revealed: "6. You have the right to privacy and confidentiality in the facility. This includes your accommodation, medical treatment, written and telephone communications, personal care, visits and	F0583		

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F0583 SS = D	Continued from page 15 meetings with family and resident groups."	F0583		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure accurate coding of the Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments for one of two	F0641	F 0641 PLAN OF CORRECTION 1. In continuing compliance with F 0641, Accuracy of Assessments, Faulkton Senior Living corrected the deficiency by submitting corrected Minimum Data Set (MDS) information for R6 and R5 on 09/17/2026. All other residents were audited to ensure weight loss and PASRR were coded correctly on most recent MDS by 10/22/2026. 2. To correct the deficiency and to ensure the problem does not recur education was provided by the Minimum Data Set Coordinator RN to Dietary Manager and Social Services Coordinator on the Accura Conducting an Accurate Resident Assessment Policy by 10/22/2026. The MDSC and/or designee will audit correct coding of weight loss and PASRR status for 1 MDS weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns from audits through the community's QA Process.	10/26/2026

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F0641 SS = D	Continued from page 16 sampled residents (6) in the area of weight loss and one of two sampled residents (5) in the area of Preadmission Screening and Resident Review (PASRR) (an evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present). Findings include: 1. Observation and interview on 9/15/26 at 1:54 p.m. with resident 6 in her room revealed she was seated in her recliner, and she stated the food was not always good. 2. Review of resident 6's electronic medical record (EMR) revealed she admitted to the facility on 12/28/23. Her 7/15/26 Brief Interview of Mental Status (BIMS) assessment score was 6, which indicated her cognition was severely impaired. Her physician ordered diet was consistent carbohydrate (focuses on keeping carbohydrate intake steady from meal to meal and day to day, to help with diabetes management) . Resident 6 was provided with a dietary supplement two times per day. Resident 6's diagnoses included dementia, Alzheimer's disease, heart disease, type 2 diabetes, and Parkinsonism (a brain disorder that primarily affects a persons' movement). Resident 6's care plan indicated that she had potential for altered nutrition related to heart disease and type 2 diabetes. Resident 6's weight record indicated that on 1/12/26 she weighed 154 pounds (lbs) and on 7/7/26 she weighed 133.0 lbs. From 1/12/26 through 7/7/26 she had lost 21 pounds. During the 180-day look-back period (defined time frame used to gather information for certain assessment items) resident 6 had a 14% weight loss. Review of resident 6's minimum data set assessment (MDS) with an assessment reference date (ARD) of 7/10/26 revealed that there was no indication of her weight loss. 3. Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025 revealed section K page 4, the definition for weight loss: "DEFINITIONS 10% WEIGHT LOSS IN 180 DAYS Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago.	F0641		

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F0641 SS = D	Continued from page 17 If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight." 4. Interview on 9/17/26 at 2:38 p.m. and again at 2:42 p.m. with registered nurse (RN)/MDS coordinator D revealed dining services manager (DSM) Q was responsible for reviewing the resident's weight record, determining if there was a weight loss or weight gain, and coding the resident's MDS assessment for that area. RN/MDS coordinator D confirmed resident 6 had a significant weight loss of over 10% that should have been documented on her 7/10/26 MDS. 5. Interview on 9/17/26 at 3:03 p.m. with DSM Q regarding resident 6's weight loss revealed she was employed by the provider for the past four years. She was not provided MDS training. She had completed some MDS training when working for another provider. When she completed a resident's comprehensive MDS assessment, she printed a "yearly weight report" from the resident's EMRs. She reviewed those weight reports and determined if there was a significant weight loss. She did not use the Resident Assessment Instrument Minimum Data Set manual instructions to calculate the weights to determine if there was a weight loss. DSM Q confirmed resident 6 had a significant weight loss of more than 10 percent during the 180-day look back period, which should have been coded on the residents 7/10/26 MDS assessment. She was not sure why she had coded resident 6's MDS assessment as no weight loss and was not aware that the provider's EMR system included access to each section of the MDS for instructions on coding. 6. Review of resident 5's EMR revealed he admitted to the facility on 12/23/19 with a confirmed Level II PASRR determination. The EMR reflected a Level II PASRR. Review of resident 5's 7/13/26 comprehensive MDS assessment indicated that item A1500 was coded "No" to the question, "Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or related condition?" Resident 5's 8/16/2026 comprehensive MDS assessment revealed A1500 was coded "No," despite the confirmed Level	F0641		

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F0641 SS = D	Continued from page 18 II determination. 7. Interview on 9/17/26 at 2:28 p.m. with social worker (SW) C revealed PASRR documents were scanned into the resident's EMRs. She confirmed Resident 5 had a Level II PASRR determination in his EMR. She stated she was responsible for entering information into MDS Sections C, D, Q, E, and S, and that Section A was completed by RN/MDS coordinator D. 8. Interview on 9/17/26 at 2:29 p.m. with RN/MDS coordinator D revealed that she was responsible for completing Section A of the resident's MDS assessments and was not aware that resident 5 had a Level II PASRR determination. She stated she used the newest version of the Resident Assessment Instrument (RAI) manual available when completing her assessments. She acknowledged that social worker C typically verified PASRR information before the residents MDS assessments were completed and was unaware how resident 5's Level II PASRR status was missed. 9. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 (October 2025) revealed that PASRR requirements must be accurately reflected in Section A1500 of the MDS. The manual indicated that the MDS assessor was responsible for verifying the resident's PASRR Level II status prior to completing Section A. The manual further directed that the assessor must ensure the PASRR determination was current, confirmed, and entered correctly to support accurate care planning and compliance with federal requirements.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F0644		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faulkton Senior Living	**1401 Pearl St , Faulkton, South Dakota, 57438**

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F0644 SS = D	Continued from page 19 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the provider failed to ensure the residents Level II Preadmission Screening and Resident Review (PASRR, an evaluation if a mental illness, intellectual disability (ID)) determination was up to date for one of one sampled resident (12) whose Level II PASRR expired on 4/26/26. Findings include: 1. Review of resident 12's electronic medical record (EMR) revealed she admitted to the facility on 10/29/25 with a diagnosis of paranoid personality disorder. Resident 12's Level II PASRR expired on 4/26/26. 2. Interview on 09/17/26 at 2:28 p.m. with social worker (SW) C revealed she was responsible for tracking PASRRs that were issues for s specific time frame or required a new screening due to a change in the residents' diagnoses or medications. She created a system to track the resident's Level II PASRRs on a calendar to ensure updates were completed when needed. She acknowledged that resident 12's PASRR was expired and stated she did not know how she missed updating her PASRR. 3. The provider did not have a policy related to Level II PASRRs.	F0644	F 0644 PLAN OF CORRECTION 1. In continuing compliance with F 0644, Coordination of PASARR and Assessments, Faulkton Senior Living corrected the deficiency by updating & receiving approval for R12's PASARR level II on 09/21/2026. All other resident PASARRs were reviewed for accuracy by 10/10/2026. 2. To correct the deficiency and ensure the problem does not recur education was provided by the Director of Nursing Services to the Social Services Coordinator related to PASARR requirements and ensuring all PASARRS are updated prior to expiration by 10/22/2026. The Director of Nursing and/or designee will audit all resident PASRR status monthly for 3 months and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns from audits through the community's QA Process.	10/26/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F0655		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faulkton Senior Living	**1401 Pearl St , Faulkton, South Dakota, 57438**

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F0655 SS = D	Continued from page 20 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the provider failed to ensure the baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was completed, reviewed with, and a copy was offered to, the resident or the resident's representative within 48 hours of	F0655	F 0655 PLAN OF CORRECTION 1. In continuing compliance with F 0655, Baseline Care Plans, Faulkton Senior Living corrected the deficiency by educating LPN E & LPN IP on the Baseline Care Plan requirements for R41 and all like residents by the Director of Nursing Services on 10/16/2026. 2. To correct the deficiency and ensure the problem does not recur all licensed nurses were educated on the Baseline Care Plan requirements by the Director of Nursing Services by 10/22/2026. The Director of Nursing Services and/or designee will audit all baseline care plans for completion and resident/resident representative offering for 3 months and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns from audits through the community's QA Process.	10/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0655 SS = D	Continued from page 21 admission to the facility for one of three newly admitted sampled residents (41). Findings include: 1. Review of resident 41's electronic medical record (EMR) revealed he admitted to the facility on 9/11/26. His baseline care plan did not include his discharge plan, how he transferred between surfaces, or if he required assistance with repositioning. The documentation on the baseline care plan indicated it was initiated by licensed practical nurse (LPN) E on 9/11/26 at 6:00 p.m. The care plan was signed by resident 41 and LPN/infection preventionist P. No documentation indicated resident 41's baseline care plan was reviewed with him or his representative, or that he or his representative was offered a copy of his baseline care plan within 48 hours of his admission to the facility. 2. Interview on 9/17/26 at 3:56 p.m. with LPN E revealed that she had started resident 41's baseline care plan on 9/11/26 but he admitted to the facility late on her shift, so she was unable to complete it. When she was unable to complete a resident's baseline care plan upon their admission to the facility, she expected the next scheduled shift nurse to complete the resident's baseline care plan within the first 24 hours after that resident's admission to the facility. She expected resident 41's baseline care plan to include his discharge plan, how he transferred and if he required assistance with repositioning. She expected residents' baseline care plans to be signed and dated when they were completed. She stated she was unable to determine if resident 41's baseline care plan was completed within 48 hours of his admission to the facility because there was no date to indicate when it was completed. LPN E did not review the baseline care plan with the residents or the residents' representatives after she completed them. She did not offer a copy of the resident's completed baseline care plan to the residents or the residents' representatives. She did not know she was supposed to review the baseline care plan and offer a copy of the resident's baseline care plan to the residents or the residents' representatives. 3. Interview and review of resident 41's baseline care plan on 9/17/26 at 3:56 p.m. with director of nursing (DON) B revealed that she expected the nurse who admitted a resident to the facility to	F0655		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0655 SS = D	Continued from page 22 complete that resident's baseline care plan and review it with the resident or the resident's representative within 24 hours of the resident's admission to the facility. She was not aware that the regulation required the resident's baseline care plan to be completed, reviewed with the resident or the resident's representative, and a copy of the resident's baseline care plan to be offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility. She expected resident 41's baseline care plan to include how he transferred between surfaces and if he required assistance with repositioning because the resident's baseline care plan directed the staff on how to care for him until his comprehensive care plan was completed. She acknowledged that it could not be determined when resident 41's care plan was completed and reviewed with him because it was not dated to indicate when that had occurred. 4. LPN/IP P was out of the facility and not available for an interview on 9/17/26. 5. The provider did not have a policy related to baseline care plans.	F0655		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F0732		

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F0732 SS = D	Continued from page 23 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the provider failed to ensure the daily nurse staffing information, including the total number and the actual hours worked by registered nurses, licensed practical nurses, licensed vocational nurses, and certified nursing assistants per shift, was posted in a location that was visible and accessible to the residents, staff, and visitors. Findings include: 1. Observation on 9/15/26 at 3:25 p.m. revealed that the posted daily nurse staffing sheet did not have the staff's total hours worked section completed. 2. Interview on 9/15/26 at 3:33 p.m. with licensed practical nurse (LPN) E revealed she was unsure of the process for completing the daily nurse staffing	F0732	F 0732 PLAN OF CORRECTION 1. In continuing compliance with F 0732, Posted Nurse Staffing Information, Faulkton Senior Living corrected the deficiency by providing education to the Director of Nursing Services on the posted nurse staffing information requirements by the Executive Director on 10/16/2026. 2. To correct the deficiency and ensure the problem does not recur education was provided by Director of Nursing Services to the licensed nursing staff on the daily posted nurse staffing information requirements by 10/22/2026. The Director of Nursing and/or designee will audit the daily nurse staff posting for total hours 2 times per week for 4 weeks, monthly for 2 months, and then randomly to ensure continued compliance. 3. As part of Faulkton Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns from audits through the community's QA Process.	10/22/2026

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F0732 SS = D	Continued from page 24 sheet. She stated the scheduled night shift nurse was responsible for filling it out, and she had never worked the night shift. She was never instructed to update the nurse staffing sheet and believed director of nursing (DON) B updated the sheet when call-ins occurred. 3. Observation on 9/16/26 at 8:35 a.m. revealed that the posted daily nurse staffing sheet did not have the staff's total hours worked section completed. 4. Interview on 9/17/26 at 3:42 p.m. with DON B revealed she believed the scheduled night shift nurse filled out the daily nurse staffing sheets, but she was not aware that the staff's total hours worked for each shift. She confirmed the missing staff hours were not being added to the daily nurse staffing sheets. 5. Review of the provider's posted daily nurse staffing sheets from 8/15/26 through 9/15/26 revealed that none of the 32 postings included the staff's total hours worked for each shift. Each posting included columns completed for staff categories, shift schedules, and the number of staff per shift, but the total hours worked column remained blank for all dates. 6. The provider's Daily Nurse Staffing Posting policy was requested but not provided by the end of the survey.	F0732		

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	435084	A. BUILDING **01 - MAIN BUILD...** B. WING	**09/15/2026**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/15/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Faulkton Senior Living was found in compliance.	K0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda R. Ferguson	Executive Director	10/09/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10619	A. BUILDING: _____ B. WING _____	09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAULKTON SENIOR LIVING	1401 PEARL ST FAULKTON, SD 57438

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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 9/15/26 through 9/17/26. Faulkton Senior Living was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda R. Ferguson
TITLE: Executive Director
(X6) DATE: 10/09/2026