

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  60139	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  C 05/14/2025
NAME OF PROVIDER OR SUPPLIER  STONEBROOK SUITES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 301 DAKOTA DUNES BLVD DAKOTA DUNES, SD 57049			
(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	Compliance Statement  A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 5/13/25 through 5/14/25. StoneyBrook Suites Assisted Living was found in compliance.  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 5/13/25 through 5/14/25. Areas surveyed included state licensure (over-level-of-care), nursing services, and physical environment. StoneyBrook Suites was found in compliance.	S 000			

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

*[Signature]*

TITLE

Administrator

(X6) DATE

5-21-25