DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 07/25/2024 FORM APPROVED OMB NO. 0938-0391

		WIEDICAID SERVICES					0. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
43L003			B. WING			07	07/18/2024	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
SIOUX FAI	LLS CHILDREN'S HOME	- RESIDENTIAL		801 N SYCAMORE POST OFFICE BOX 1749 SIOUX FALLS, SD 57101				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETION DATE		
N 000	Initial Comments		N	000				
	Part 483, Subpart G, 483.354-483.376, Co the use of Restraint of Residential Treatmen Inpatient Psychiatric	ndition of Participation for or Seclusion in Psychiatric of Facilities Providing Services for Individuals conducted on 7/16/24 through Children's Home -						
	-							
LABORATORY	DIRECTOR'S OR DROWNER	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(¥6) DATE	
	Mikello	Marellee	•	ny ha ava	('80)	P/2	24	
other safeguar following the d	ds provide sufficient protect ate of survey whether or no	sterisk (*) denotes a deficiency which the ion to the patients. (See instructions.) Ex t a plan of correction is provided. For nur are made available to the facility. If defici-	cept for nursi sing homes, t	ing homes, he above fi	the findings stated above are disclos indings and plans of correction are dis	able 90 days sclosable 14	5	

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

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Facility ID: 55072

If continuation sheet Page 1 of 1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED						
		43L003	B. WING			07/18/2024					
NAME OF PROVIDER OR SUPPLIER SIOUX FALLS CHILDREN'S HOME - RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 801 N SYCAMORE POST OFFICE BOX 1749 SIOUX FALLS, SD 57101							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE				
E 000	LS CHILDREN'S HOME - RESIDENTIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOTE TAG CROSS-REFERENCED TO THE APPR		D BE COMPLETION					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE (X6) DATE											

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 available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolèté' Eventilio QWEV11

Facility ID: 55072

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