

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

PRINTED: 07/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER LIFESCAPE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105		
(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	
W 000	INITIAL COMMENTS A focused fundamental survey for compliance with 42 CFR Part 483, Subpart 1, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities was conducted from 6/24/25 through 6/25/25. LifeScape was found in compliance. A complaint survey for compliance with 42 CFR Part 483, Subpart 1, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities was conducted on 6/25/25. The areas surveyed were potential verbal abuse by a staff member to a client, and following a client's Individual Service Plan. LifeScape was found in compliance.	W 000			

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

Steve White

TITLE

CEO

(X6) DATE

7/8/2025

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER LIFESCAPE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105		
(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	
E 000	Initial Comments A focused fundamental survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities, was conducted on 6/24/25. Lifescape was found in compliance.	E 000			

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(X6) DATE

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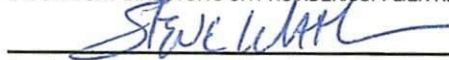
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ADMINISTRATION B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2025
NAME OF PROVIDER OR SUPPLIER LIFESCAPE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 W 26TH ST SIOUX FALLS, SD 57105		
(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	
K 000	INITIAL COMMENTS A focused fundamental survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/24/25. Lifescape (building 01) was found in compliance with 42 CFR 483.470(j)(2)(I) requirements for intermediate care facilities for individuals with intellectual disabilities.	K 000			

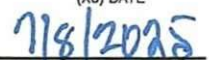
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